

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

POLICY NUMBER: 10B-1

POLICY TITLE: Appeal/Grievance and External Review Procedures for State of Wisconsin Employee Group Health Plan (WISE)

POLICY STATEMENT: To assure a timely, efficient and consistent process for administering appeal/grievance procedures for participants covered by WISE.

PROCEDURE:

1. Follow Medical Associates Health Plans (MAHP) Administrative Policy 10B-2: Appeal (Verbal) for Commercial – Wisconsin procedures and Medical Associates Health Plans (MAHP) Administrative Policy 10B: Grievance-Appeal Procedures for Commercial Members - Wisconsin. Also see State of Wisconsin Group Health Insurance Program Agreement.
2. Health plans are required by contract to inform members of their right to request a review by an Independent Review Organization in accordance with Wis. Stat. § 632.835 and Wis. Admin. Code § INS 18.11 if they disagree with the health plan’s final decision related to denials based on medical necessity, experimental treatment or other medically related reasons. See section III.I. Grievances and Appeals 6. External Review of the State of Wisconsin Group Health Insurance Program Agreement (ET-1136).
 - a. Attachment A is sent to a participant if they disagree with the health plan’s final grievance decision and, for those grievances that qualify under Wisconsin law, includes the option for an independent external review option conducted by an Independent Review Organization (IRO). A copy of the Wisconsin Independent Review Process Fact Sheet will be included with the letter.
3. Health plans are required to inform participants of their right to request a determination from ETF if they disagree with the health plan’s final decision. See section 8.A. Grievances and Appeals of the State of Wisconsin Group Health Insurance Program Certificate of Coverage (ET-2180).
 - b. Attachment B is sent to a participant if they disagree with the health plan’s final grievance decision, but the grievance does not qualify for independent review by an IRO under Wisconsin law. This letter instead includes an option for review by the Department of Employee Trust Funds (ETF). When a request for independent external review is received by MAHP, written notification of the receipt must be sent to the selected IRO and ETF **within five (5) calendar days**. MAHP will notify ETF of the members request via secure e-mail to ombudsperson@etf.state.wi.us.
3. Within fourteen (14) calendar days, MAHP will notify ETF of the IRO’s final decision and outcome, including the cost of the IRO review via secure e-mail to ombudsperson@etf.state.wi.us. ETF will track all independent review requests and decisions and provide summary information in the annual report to the Group Insurance Board.
4. On an annual basis, health plans are required to report all grievance and independent external reviews to ETF via the format specified by ETF.

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Attachments:

- A. Wisconsin Grievance Resolution Letter – With IRO Option
- B. Wisconsin Grievance Resolution Letter – Without IRO Option
- C. Fact Sheet on the Independent Review Process in Wisconsin from the OCI.

Barb Koerperich, MSN
Director of Quality and Health Care Services

Date

Karen Hoffmann
Director of Operations

Date

Jill Mitchell
Chief Operating Officer

Date

Original Effective Date: 01/05
Revised Date(s): 05/06, 02/07, 01/08, 11/09, 11/10, Moved to Operations Manual – 05/11, 07/12, 04/13, 04/14, 05/15, 05/16, 05/17, 02/18, 3/19, 3/20, 9/22, 6/23

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**Attachment A
Wisconsin Grievance Resolution Letter With 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 to review and resolve the matter relating to a denial of services for you at Provider on DOS.

With respect to your request for these services, your State of Wisconsin Group Health Insurance Program Agreement, , 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. The conclusion of the Grievance Committee was that based upon the terms of the State of Wisconsin Group Health Insurance Program Agreement, services were appropriately denied at Provider/location.

You have now exhausted our grievance process. If you disagree with the decision made on your grievance, you may request an independent external review by an Independent Review Organization (IRO). An IRO is not part of our health plan and has the authority to either uphold or overturn a grievance decision when the denial of coverage is based on medical judgment. You have four months from your receipt of this letter to request an independent external review. The request must be made in writing to the health plan at the address set forth above. In your written request, please indicate that you are requesting an independent external review and include any additional information to support your request. You do not have to resend the information that was submitted for your grievance.

This review will be done at no cost to you. Please note that an IRO decision is binding for both the health plan and the member, except for a decision regarding a preexisting condition exclusion or the rescission of a policy or certificate.

If you would like more information about filing a request for independent external review, you can go to the Wisconsin Office of the Commissioner of Insurance website at oci.wi.gov, or you may contact the Department of Employee Trust Fund's Ombudsperson Services Program at:

Local Madison: (608) 261-7947
Toll Free: (877) 533-5020
Email: ombudsperson@etf.state.wi.us

An IRO may decline to consider your request to review because it believes your request is beyond the scope of their jurisdiction or past the filing deadline of four months. In that case, you may also contact the Ombudsperson Services Program to discuss the possibility of appealing that decision.

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

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Sincerely,

Laura A. Boge
Member Services Manager

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

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)

**Attachment B
Wisconsin Grievance Resolution Letter Without IRO Option**

**MEDICAL ASSOCIATES HEALTH PLANS
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Date

Name

Address

City, State ZIP

Dear Name:

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

With respect to your request for these services, your State of Wisconsin Group Health Insurance Program Agreement, 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. The conclusion of the Grievance Committee was that based upon the terms of the State of Wisconsin Group Health Insurance Program Agreement, **services** were appropriately denied at **Provider/location**.

You have now exhausted our grievance process and have the right to request a review of your grievance by the Department of Employee Trust Funds (ETF). You may call or send a letter to ETF and request a complaint form (ET-2405). This form is also available on ETF's website at etf.wi.gov.

Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931
(608) 261-7947

Your written request must be received by ETF within 60 calendar days of the date of this letter. Requests should contain all pertinent documentation, including this grievance decision letter and a description of the contract provisions related to your issue. Your complaint will be referred to an Ombudsperson for review and investigation.

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

Sincerely,

Laura A. Boge
Member Services Manager

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

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the basis of race, color, national origin, age, disability, or sex.

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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)

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

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FAQ SHEET
PI-203 (R 11/2020)

Independent Review Process in Wisconsin

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).

Requesting an Independent Review

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 can conduct an independent and unbiased review of your claim.

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

1. An independent review is available when your health plan denies coverage for treatment because it maintains the treatment is not medically necessary or it is experimental. This includes 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 be a covered benefit under the insurance contract.
2. An independent review is available when your health plan denies you coverage for treatment based on a preexisting condition exclusion.
3. You may 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 claims that you did not answer the health questions on the insurance application completely and accurately.
4. If you and your insurer disagree about whether 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?

1. 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 treatments, your request to have the insurer cover your weight loss treatment would not be eligible for independent review, even if you believe the treatment is medically necessary.
2. 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 can ask the insurer to review your concerns through its internal grievance process.
3. 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.

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 four months** of the date the grievance procedure was completed.

For more information or to file a complaint, visit our website or contact:

Office of the Commissioner of Insurance, 125 South Webster Street, P.O. Box 7873, Madison, WI 53707-7873
p: 608-266-3585 | p: 1-800-236-8517 | f: 608-266-9935 | ociinformation@wisconsin.gov | oci.wi.gov

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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 the IRO?

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

Is there a cost?

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

Independent Review Timeline

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 an independent review or if you need immediate medical care.

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

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 another 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, it will notify you to first complete the internal grievance process.

How long does the independent review process take?

Within **five business days**, the insurer must send to the IRO:

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

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

If the IRO determines this time could jeopardize your life or health, the insurer must send its documentation within one day and the IRO then has **two 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.

Who conducts the independent reviews?

The independent review process allows you 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

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medical condition. The clinical peer reviewer is generally a board-certified physician or another 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.

How does the IRO make its decision?

The IRO must consider all 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 finds that the treatment is approved by the FDA, when required, and when medically and scientifically accepted evidence shows that 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 at [cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/External-Appeals](https://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/External-Appeals).

For more information on the entire appeals process, see the Health Insurance Grievances and Complaints publication at oci.wi.gov/Pages/Consumers/PI-217.aspx.

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. You can find a complaint form at oci.wi.gov/complaints.

OCI Contact Information

oci.wi.gov

ocicomplaints@wisconsin.gov

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

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

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

Always include your name and phone number.

Independent Review Organizations Certified to Perform Independent Reviews in Wisconsin:

oci.wi.gov/Pages/Consumers/IndependentReviewOrganizations.aspx

Further questions regarding IROs may be directed to: ocihmo@wisconsin.gov