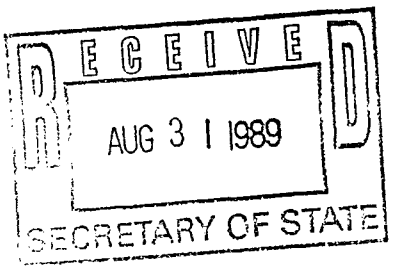
CR 88-184



STATE OF WISCONSIN)
)
OFFICE OF THE COMMISSIONER OF INSURANCE)

TO ALL TO WHOM THESE PRESENTS SHALL COME, GREETINGS:

I, Robert D. Haase, Commissioner of Insurance and custodian of the official records of said Office, do hereby certify that the annexed order repealing, renumbering, amending, and creating a rule relating to grievance procedure requirements in preferred provider plans, health maintenance organizations, and limited service health organizations was issued by this Office on the 31st day August, 1989.

I further certify that said copy has been compared by me with the original on file in this Office and that the same is a true copy thereof, and of the whole of such original.

IN TESTIMONY WHEREOF, I have hereunto subscribed my name in the City of Madison, State of Wisconsin, this 31st day of August, 1989.

Robert D. Haase
Commissioner of Insurance

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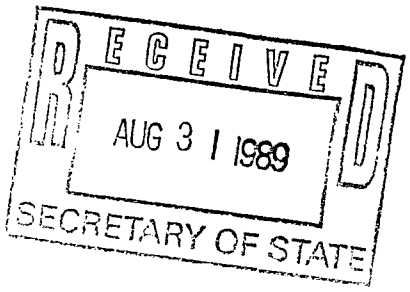

ORDER OF THE COMMISSIONER OF INSURANCE

REPEALING, RENUMBERING, AMENDING, AND CREATING A RULE

To repeal ss. Ins 3.50 (10) (d) and 3.51 (10) (d); to renumber ss. Ins 3.48 (2), (3), (4) and (5), 3.50 (3) (b) and (10) (c) and 3.51 (3) (b) and (10) (c); to amend ss. Ins 3.50 (10) (a) and (b) and 3.51 (10) (a) and (b); and to create ss. Ins 3.48 (2) and (7), 3.50 (3) (b) and (c), and (10) (c), (d), (f), (g), and (h), and 3.51 (3) (b) and (c), and (10) (c), (d), (f), (g), and (h), relating to grievance procedure requirements in preferred provider plans, health maintenance organizations and limited service health organizations.

ANALYSIS PREPARED BY THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 601.41 (3) and 609.15 (1) (a), Stats.

Statutes interpreted: s. 609.15, Stats.

The purpose of this rule is to clarify the grievance procedure information that preferred provider plans (PPPs), health maintenance organizations (HMOs), and limited service health organizations (LSHOs) must report to the commissioner under s. 609.15, Stats. Information currently reported to the commissioner varies considerably. This hampers the commissioner's ability to review and evaluate the information.

The rule adds a subsection to the current PPP rule concerning the grievance procedure. The current rules for HMOs and LSHOs already contain a similar subsection.

The rule defines "complaint" and "grievance."

The rule requires a PPP, HMO, or LSHO to include in the grievance procedure a method whereby the enrollee has a right to appear before the grievance committee. The PPP, HMO, or LSHO must notify the enrollee of the meeting place and time. The grievance must be resolved, unless certain conditions are met, within 30 calendar days. The enrollee must have the right to present oral or written information and to question those people responsible for making the determination which resulted in the grievance.

The rule requires a PPP, HMO, or LSHO to establish separate grievance procedures for urgent care situations. These grievances shall be resolved within 4 business days.

The rule requires a claim or benefit denial notice to state the specific reason for the benefit denial.

The rule requires that a PPP, HMO, or LSHO must report to the commissioner only grievances formally reviewed by a grievance panel. A PPP, HMO, or LSHO need not report to the commissioner records concerning complaints and grievances resolved prior to a formal review or in which the enrollee does not pursue resolution, but must keep those records in a central location and make them available to the commissioner upon examination or request.

The rule requires every agreement between a PPP, HMO, or LSHO and a provider to contain a clause under which the provider must identify and forward to the PPP, HMO, or LSHO any complaint or grievance received by the provider.

The rule requires each PPP, HMO, or LSHO to report to the commissioner by March 1 of each year. The report must provide information on grievances received during the previous calendar year. The rule requires PPPs, HMOs, and LSHOs to categorize grievances reported to the commissioner as relating to plan administration or claims denial.

The rule requires the commissioner to prepare an annual report summarizing complaints received by the commissioner's office regarding PPPs, HMOs, and LSHOs, and the grievance experience reports filed with the office by PPPs, HMOs, and LSHOs.

SECTION 1. Ins 3.48 (2), (3), (4) and (5) are renumbered Ins 3.48 (3), (4), (5) and (6).

SECTION 2. Ins 3.48 (2) and (7) are created to read:

Ins 3.48 (2) **DEFINITIONS.** In this section:

(a) "Complaint" means any dissatisfaction about an insurer or its contracted providers expressed by an enrollee.

(b) "Grievance" means any dissatisfaction with the administration or claims practices of or provision of services by a preferred provider plan which is expressed in writing by or on behalf of a plan enrollee.

Ins 3.48 (7) **GRIEVANCE PROCEDURE.** (a) A preferred provider plan shall investigate each grievance pursuant to s. 609.15 (2), Stats. Each preferred provider plan shall develop an internal grievance procedure and shall describe the grievance procedure in each policy and certificate issued to enrollees. Policies and certificates shall include a definition of a grievance.

(b) In addition to the notice requirement under par. (a), each time the preferred provider plan denies a claim or benefit, including a refusal to

refer an enrollee, or initiates disenrollment proceedings, the preferred provider plan shall notify the affected enrollee of the right to file a grievance and the procedure to follow. The notification shall state the specific reason for the denial or initiation.

(c) A preferred provider plan shall resolve all grievances within 30 calendar days of receiving the grievance. If the preferred provider plan is unable to resolve the grievance within 30 calendar days, the time period may be extended an additional 30 calendar days if the preferred provider plan notifies, in writing, the person who filed the grievance that the preferred provider plan has not resolved the grievance, when resolution may be expected, and the reason for why additional time is needed.

(d) A grievance procedure shall include a method whereby the enrollee who made the grievance has the right to appear in person before the grievance committee to present written or oral information and to question those people responsible for making the determination which resulted in the grievance. The preferred provider plan shall inform the enrollee in writing of the time and place of the meeting at least 7 calendar days before the meeting.

(e) Pars. (b), (c) and (d) do not apply in urgent care situations. Preferred provider plans shall develop a separate grievance procedure for urgent care situations. This procedure shall require a preferred provider plan to resolve an urgent care situation grievance within 4 business days of receiving the grievance.

(f) Preferred provider plans shall record, retain, and report records for each complaint and grievance in accordance with all of the following requirements:

1. Each preferred provider plan shall keep and retain for at least a three-year period a record for each complaint and grievance submitted to the preferred provider plan.

2. Each provider contract and administrative services agreement entered into between a preferred provider plan and a provider shall contain a provision under which the provider must identify complaints and grievances and forward these complaints and grievances in a timely manner to the preferred provider plan for recording and resolution.

3. Each preferred provider plan shall submit the grievance experience report required by s. 609.15 (1) (c), Stats., to the commissioner by March 1 of each year. The report shall provide information on grievances that were formally reviewed by a grievance panel of the preferred provider plan during the previous calendar year. For purposes of this report, the preferred provider plan shall classify each grievance as follows:

a. Plan administration. A grievance related to plan marketing, policyholder service, billing, underwriting, or similar administrative functions; or

b. Benefit denials. A grievance related to the denial of a benefit, including grievances related to refusals to refer enrollees or provide requested services.

4. Each preferred provider plan shall keep together in a central location of the preferred provider plan all records on complaints and grievances resolved before a formal review by a grievance panel is completed or in which the enrollee does not pursue a resolution. Preferred provider plans shall make these records available for review during examinations by or on request of the commissioner.

(g) The commissioner shall by June 1 of each year prepare a report that summarizes grievance experience reports received by the commissioner from preferred provider plans. The report shall also summarize complaints involving preferred provider plans that were received by the office during the previous calendar year.

SECTION 3. Ins 3.50 (3) (b) is renumbered Ins 3.50 (3) (d).

SECTION 4. Ins 3.50 (3) (b) and (c) are created to read:

Ins 3.50 (3) (b). "Complaint" means any dissatisfaction about an insurer or its contracted providers expressed by an enrollee.

(3) (c) "Grievance" means any dissatisfaction with the administration or claims practices of or provision of services by a health maintenance organization which is expressed in writing by or on behalf of a plan enrollee.

SECTION 5. Ins 3.50 (10) (a) and (b) are amended to read:

Ins 3.50 (10) (a) A health maintenance organization shall investigate each grievance pursuant to s. 609.15 (2), Stats. Each health maintenance organization shall develop an internal grievance procedure which shall be described in each policy and certificate issued to enrollees. Policies and certificates shall include a definition of a grievance.

(b) In addition to the notice requirement under par. (a), each time the health maintenance organization denies a claim or benefit, including a refusal to refer an enrollee, or initiates disenrollment proceedings, the health maintenance organization shall notify the affected enrollee of the right to file a grievance and the procedure to follow. The notification shall state the specific reason for the denial or initiation.

SECTION 6. Ins 3.50 (10) (c) is renumbered Ins 3.50 (10) (f).

SECTION 7. Ins 3.50 (10) (c) is created to read:

Ins 3.50 (10) (c) A health maintenance organization shall resolve all grievances within 30 calendar days of receiving the grievance. If the health maintenance organization is unable to resolve the grievance within 30 calendar days, the time period may be extended an additional 30 calendar days if the health maintenance organization notifies, in writing, the person who filed the grievance that the health maintenance organization has not resolved the grievance, when resolution may be expected, and the reason for why additional time is needed.

SECTION 8. Ins 3.50 (10) (d) is repealed.

SECTION 9. Ins 3.50 (10) (d), (e), (g) and (h) are created to read:

Ins 3.50 (10) (d) A grievance procedure shall include a method whereby the enrollee who made the grievance has the right to appear in person before the grievance committee to present written or oral information and to question those people responsible for making the determination which resulted in the grievance. The health maintenance organization shall inform the enrollee in writing of the time and place of the meeting at least 7 calendar days before the meeting.

(10) (e) Pars. (b), (c) and (d) do not apply in urgent care situations. Health maintenance organizations shall develop a separate grievance procedure for urgent care situations. This procedure shall require a health maintenance organization to resolve an urgent care situation grievance within 4 business days of receiving the grievance.

(10) (g) Health maintenance organizations shall record, retain, and report records for each complaint and grievance in accordance with all of the following requirements:

1. Each health maintenance organization shall keep and retain for at least a three-year period a record for each complaint and grievance submitted to the health maintenance organization.

2. Each provider contract and administrative services agreement entered into between a health maintenance organization and a provider shall contain a provision under which the provider must identify complaints and grievances in a timely manner and forward these complaints and grievances in a timely manner to the health maintenance organization for recording and resolution.

3. Each health maintenance organization shall submit a grievance experience report required by s. 609.15 (1) (c), Stats., to the commissioner by March 1 of each year. The report shall provide information on grievances received during the previous calendar year that were formally reviewed by a grievance panel of the health maintenance organization. For purposes of this report, the health maintenance organization shall classify each grievance as follows:

a. Plan administration. A grievance related to plan marketing, policyholder service, billing, underwriting, or similar administrative functions; or

b. Benefit denials. A grievance related to the denial of a benefit, including grievances related to refusals to refer enrollees or provide requested services.

4. Each health maintenance organization shall keep together in a central location of the health maintenance organization all records on complaints and grievances resolved before a formal review by a grievance panel is completed or in which the enrollee does not pursue a resolution. The

health maintenance organization shall make these records available for review during examinations by or on request of the commissioner.

(10) (h) The commissioner shall by June 1 of each year prepare a report that summarizes grievance experience reports received by the commissioner from health maintenance organizations. The report shall also summarize complaints involving health maintenance organizations that were received by the office during the previous calendar year.

SECTION 10. Ins 3.51 (3) (b) is renumbered Ins 3.51 (3) (d).

SECTION 11. Ins 3.51 (3) (b) and (c) are created to read:

Ins 3.51 (3) (b). "Complaint" means any dissatisfaction about an insurer or its contracted providers expressed by an enrollee.

(3) (c). "Grievance" means any dissatisfaction with the administration or claims practices of or provision of services by a limited service health organization which is expressed in writing by or on behalf of a plan enrollee.

SECTION 12. Ins 3.51 (10) (a) and (b) are amended to read:

Ins 3.51 (10) (a) A limited service health organization shall investigate each grievance pursuant to s. 609.15 (2), Stats. Each limited service health organization shall develop an internal grievance procedure which shall be described in each policy and certificate issued to enrollees. Policies and certificates shall include a definition of a grievance.

(10) (b) In addition to the notice requirement in par. (a), each time the limited service health organization denies a claim or benefit, including a refusal to refer an enrollee, and each time it initiates disenrollment proceedings under sub. (12) (b) 5, the limited service health organization shall notify the affected enrollee of the right to file a grievance and the

procedure to follow. The notification shall state the specific reason for the denial or initiation.

SECTION 13. Ins 3.51 (10) (c) is renumbered Ins 3.51 (10) (f).

SECTION 14. Ins 3.51 (10) (c) is created to read:

Ins 3.51 (10) (c) A limited service health organization shall resolve all grievances within 30 calendar days of receiving the grievance. If the limited service health organization is unable to resolve the grievance within 30 calendar days, the time period may be extended an additional 30 calendar days if the limited service health organization notifies, in writing, the person who filed the grievance that the limited service health organization has not resolved the grievance, when resolution may be expected, and the reason for why additional time is needed.

SECTION 15. Ins 3.51 (10) (d) is repealed.

SECTION 16. Ins 3.51 (10) (d), (e), (g) and (h) are created to read:

Ins 3.51 (10) (d) A grievance procedure shall include a method whereby the enrollee who made the grievance has the right to appear in person before the grievance committee to present written or oral information and to question those people responsible for making the determination which resulted in the grievance. The limited service health organization shall inform the enrollee in writing of the time and place of the meeting at least 7 calendar days before the meeting.

(10) (e) Pars. (b), (c) and (d) do not apply in urgent care situations. Limited service health organizations shall develop a separate grievance procedure for urgent care situations. This procedure shall require a limited service health organization to resolve an urgent care situation grievance within 4 business days of receiving the grievance.

(10) (g) Limited service health organizations shall record, retain, and report records for each complaint and grievance in accordance with all of the following requirements:

1. Each limited service health organization shall keep and retain for at least a three-year period a record for each complaint and grievance submitted to the limited service health organization.

2. Each provider contract and administrative services agreement entered into between a limited service health organization and a provider shall contain a provision under which the provider must identify complaints and grievances and forward these complaints and grievances in a timely manner to the limited service health organization for recording and resolution.

3. Each limited service health organization shall submit a grievance experience report required by s. 609.15 (1) (c), Stats., to the commissioner by March 1 of each year. The report shall provide information on grievances received during the previous calendar year that were formally reviewed by a grievance panel of the limited service health organization. For purposes of this report, the limited service health organization shall classify each grievance as follows:

a. Plan administration. A grievance related to plan marketing, policyholder service, billing, underwriting, or similar administrative functions; or

b. Benefit denials. A grievance related to the denial of a benefit, including grievances related to refusals to refer enrollees or provide requested services.

4. Each limited service health organization shall keep together in a central location of the limited service health organization all records on complaints and grievances resolved before a formal review by a grievance panel

is completed or in which the enrollee does not pursue a resolution. The limited service health organizations shall make these records available for review during examinations by or on request of the commissioner.

(10) (h) The commissioner shall by June 1 of each year prepare a report that summarizes grievance experience reports received by the commissioner from limited service health organizations. The report shall also summarize complaints involving limited service health organizations that were received by the office during the previous calendar year.

EFFECTIVE DATE. Pursuant to s. 227.22 (2) (b), Stats., this rule shall first take effect on January 1, 1990.

Dated at Madison, Wisconsin, this 31st day of August, 1989.

Robert D. Haase
Commissioner of Insurance