

COMPLAINT SYSTEM and APPEAL PROCEDURES/
MANAGED CARE HEALTH INSURANCE PLAN (MCHIP) FILING REQUIREMENTS

The following requirements apply to all health carriers, but not to stand-alone dental and stand-alone vision MCHIPs. Requirements related to stand-alone dental and stand-alone vision MCHIPs are located in Part 5 at the end of this document.

MCHIPs must submit to the Bureau of Insurance for approval its complaint and appeal procedures and any subsequent material changes to such procedures. In addition, MCHIPs must include a description of their complaint systems with the submission of the annual complaint report. Approval of the complaint system filing and appeal procedures does not constitute an approval of the EOC or any documents subject to filing and approval requirements pursuant to §§ 38.2-316 and 38.2-4306 of the Code of Virginia. Approval of such forms is a separate function within the Bureau. Complaint system filings /appeal procedures should include a description of when and in what manner procedures are distributed, and must also document, (procedurally or by including applicable forms/correspondence), compliance with the following requirements:

PART 1 – PROCESS REQUIREMENTS (Health Carriers)		
REFERENCES	COMMENTS	DOCUMENT NAME/ PAGE #/ SECTION #
General Internal Appeal Requirements		
14VAC5-216-30	<ul style="list-style-type: none"> • Process shall not inhibit/hamper claims process. • Carrier must allow an authorized representative to act on behalf of person pursuing a benefit claim or adverse benefit determination. <ul style="list-style-type: none"> ○ Carrier may or may not establish procedures to determine whether representative is authorized. ○ In an urgent care appeal, the physician can be a representative. • Internal appeals procedure must have administrative processes to ensure that adverse benefit determinations are made according to and consistently with benefit plans. 	
Minimum Internal Appeal Requirements		
14VAC5-216-40	<ul style="list-style-type: none"> A. Appeal can be made within 180 days of receipt of adverse benefit determination. <ul style="list-style-type: none"> 1. Carrier may or may not appoint utilization review entity to coordinate review. B. Carrier must ensure independence and impartiality of individuals involved in reviewing the appeal. C. <ul style="list-style-type: none"> 1. If it involves medical judgment, a clinical peer reviewer must be used to review appeal. 2. Any reviewer of appeal must not be previously affiliated with claim. 	

	<p>D. Every review must be full and fair:</p> <ol style="list-style-type: none"> 1. Provides person with opportunity to submit other information relating to the appeal. 2. Person may request and access any documents related to the request for benefits and the information shall be provided as soon as practicable. <ul style="list-style-type: none"> o Request for diagnosis or treatment codes should NOT be considered a request for an appeal. 3. Provides an appeal process that considers ALL documents, comments, records, and information submitted by person. 4. Provides identification of the expert whose advice was obtained for adverse benefit determination. 5. Provides urgent care appeals process. 6. Before adverse benefit determination, carrier must provide all new or additional evidence used or generated by carrier sufficiently in advance so person can respond in timeframe. <p>E. Carrier must notify person of final benefit determination within appropriate timeframe to medical circumstances.</p> <ol style="list-style-type: none"> 1. If pre-service request, carrier has 30 days after receipt of appeal to notify person. <ul style="list-style-type: none"> o Carrier may provide 2nd level of internal appeal for ONLY group health plans; 15 days allowed for response to appeal at each level. 2. If post-service request, carrier has 60 days after receipt of appeal to notify person. <ul style="list-style-type: none"> o Carrier may provide 2nd level of internal appeal for ONLY group health plans; 30 days allowed for response to appeal at each level. 	
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Urgent Care Appeals

14VAC5-216-50	<p>A. Carrier must notify person of initial determination ASAP, no later than 72 hours after receipt.</p> <ul style="list-style-type: none"> o If given information is insufficient, carrier must notify person of info needed ASAP, no later than 24 hours after receipt. o The person must have at least 48 hours to submit specified information. o Carrier must notify person of determination no later than 48 hrs. after (i) the receipt of specified information; or (ii) the end of the period given to the person to provide info, whichever is earlier. <p>B. Person may submit request for urgent care appeal orally or in writing to carrier.</p> <p>C. Necessary info must be exchanged by most expeditious method available.</p> <p>D. Carrier must notify person of determination within 72 hours of receipt of urgent care appeal.</p>	
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Concurrent Review Decisions

14VAC5-216-60	<ul style="list-style-type: none"> • Reduction or termination of approved treatment to be provided over time or over a number of treatments constitutes an adverse benefit determination. <ul style="list-style-type: none"> o Carrier must notify person sufficiently in advance to allow person to file an internal appeal and obtain determination before benefits are reduced/terminated. 	
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	<ul style="list-style-type: none"> Urgent care appeal requests for extension of time or number of treatments must be decided ASAP, taking medical exigencies into account; the person and physician are notified of determination within 72 hours after receipt of internal appeal. Carrier must continue coverage pending the outcome of internal appeal of concurrent review decision. 	
Exhaustion of internal appeal process		
§38.2-3560 14VAC5-216-40 E 14VAC5-216-45	<p>Covered person must exhaust internal process to submit request for external review. Process is exhausted when:</p> <ul style="list-style-type: none"> Covered person has completed standard internal appeals process. Covered person does not receive timely decision from carrier (30/60 days after appeal was received by carrier). Expedited internal appeal is requested, therefore can request an expedited external review at the same time. Carrier waives exhaustion requirement. Carrier violates Virginia internal appeal requirements, unless it is a de minimus violation beyond carrier's control and does not cause prejudice or harm to covered person if the carrier can show the violation was for good cause or beyond carrier's control and the violation happened while the carrier and covered person were exchanging information. Violations that are a pattern with carrier will not be de minimus. <ul style="list-style-type: none"> Covered person may request written explanation of violation from carrier. Carrier must provide written explanation in 10 days. Covered person may request IRO review to determine if the carrier has violated this provision. <ul style="list-style-type: none"> IRO will conduct review and provide a written response to covered person, carrier and Commission within 10 days. Carrier must pay for IRO review. If rejected, within 5 days health carrier must notify covered person of their right to resubmit the internal appeal. 	

PART 2 - NOTICE REQUIREMENTS (Health Carriers)			
REFERENCES	WHEN REQUIRED	WHAT	DOCUMENT NAME/ PAGE #/ SECTION #
§ 38.2-5803 A 14 VAC5-211-210	At time of enrollment or time EOC is issued and available upon request or at least annually	<ul style="list-style-type: none"> Information must include: <ul style="list-style-type: none"> Description of method to resolve enrollee complaints (for HMOs, must be included in EOC). Required language (§38.2-5803 A 5). Contact information for the Office of Managed Care Ombudsman: telephone, email, mailing address. 	

		Note: Approval of the EOC form is a separate function within the Bureau. Approval of the complaint system filing does not constitute an approval of the EOC or any documents subject to filing and approval requirements pursuant to §§ 38.2-316 and 38.2-4306 of the Code of Virginia.	
§38.2-3570 14VAC5-216-20	Must be in or attached to policy, certificate, membership booklet, outline of coverage, or EOC	Description of external review procedures to include: <ul style="list-style-type: none"> • Statement that informs covered person of right to file request for external review of adverse determination & final adverse determination with BOI; • Explanation of availability of external review when adverse determination & final adverse determination involves medical necessity, appropriateness, healthcare setting, level of care, or effectiveness or is determined to be experimental or investigational; • Contact information of BOI: <ul style="list-style-type: none"> ○ Telephone number and address; • Notification to the covered person that they must authorize the release of any medical records needed to reach a decision on the external review. 	
14VAC5-216-30	As part of health benefit plan and in any adverse benefit determination	<ul style="list-style-type: none"> • Carrier must establish an internal appeals procedure that complies with 29 USC § 2560.503-1 and 45 CFR § 147.136 and provide notice of this process, to include: <ul style="list-style-type: none"> ○ Timeframes to submit internal appeal and for company response--standard and expedited appeals (refer to flowcharts); ○ Contact information of unit coordinating review of appeal: <ul style="list-style-type: none"> ▪ Name, address, telephone number; ○ Contact information for the Bureau of Insurance (if MCHIP, not needed in adverse determination); ○ Contact information for the Office of Managed Care Ombudsman, if MCHIP: <ul style="list-style-type: none"> ▪ Mailing address, email, and telephone number. 	
§ 38.2-5804 A 2 §38.2-3558 14VAC5-216-30A	With adverse benefit determination and upon request	In addition to the above notice requirements with any adverse benefit determination, MCHIPs must provide complaint forms and/or written procedures that include: <ul style="list-style-type: none"> • Address and phone number of MCHIP department or contact person to which/whom complaints are to be directed; • Mailing address, telephone number and e-mail address of the Office of the Managed Care Ombudsman; • Required time limits/deadlines for filing complaints/appeals; • Clear and understandable description of enrollee's internal appeal rights for adverse determinations pursuant to § 32.1-137.15 and §38.2-3558. 	

<p>§38.2-3559 14VAC5-216-40E 14VAC5-216-70 Administrative Letter 2011-05</p>	<p>With any adverse determination</p>	<p>In addition to the above notice requirements with any adverse benefit determination, health carriers must provide:</p> <ul style="list-style-type: none"> • The standard and expedited external review processes (including required language) (§38.2-3559 A); • Notice that: <ul style="list-style-type: none"> ○ expedited external review is available if medically needed (§38.2-3562 A 1); ○ expedited external review is available for certain experimental/ investigational treatments (§38.2-3563); ○ expedited internal appeal and expedited external review can be requested at the same time (§38.2-3562 or §38.2-3563); ○ if carrier takes longer than 30 days pre-service/ 60 days post-service for review and response without request or agreement of delay, person can request an external review; • Carrier must provide notice of website and phone numbers so the covered person may access forms to request an external review prior to the final adverse determination in the above circumstances. • Forms to request an external review must be provided with any final adverse determination. • For final adverse determinations, provide notice of expedited external review available if the final adverse determination involves admissions, availability of care, continued stay or health care service for emergency care when patient received emergency services, but has not been discharged from a facility. 	
<p>14VAC5-216-70 §38.2-3559 C</p>	<p>Notice of adverse benefit determination following appeal</p>	<p>In addition to the above notice requirements with any adverse benefit determination or adverse determination, health carriers must provide:</p> <p>A. Written or electronic notification of adverse benefit determination on appeal to covered person; must be easy to understand, and must include:</p> <ol style="list-style-type: none"> 1. Identification of claim (date of service, provider, claim amount, and a statement of availability, upon request, of diagnosis code and treatment code and their meanings). If the covered person requests this information, the carrier cannot consider this an appeal; 2. Reasons for adverse benefit determination; 3. Reference to plan provision on which adverse benefit determination is made; 4. Statement saying that the person has access to all of documents related to claim; 	

		<p>5. Statement:</p> <ul style="list-style-type: none"> i. Indicating internal appeals available with contact info to submit appeal; or ii. Indicating person has received final adverse determination; <p>6. Statement describing:</p> <ul style="list-style-type: none"> i. External review procedures; ii. Person’s right to obtain info about procedures; iii. Person’s right to bring civil action under §502(a) of ERISA if applicable; <p>7. Statement saying that person has right to request an external review if a final adverse determination has not been received in provided timeframe (14VAC5-216-40 E) unless person requests or agrees to a delay.</p> <p>B. In group health plans, required notification must also include:</p> <ul style="list-style-type: none"> 1. If a rule was used to make an adverse benefit determination, the copy of the rule will be provided to the person upon request; 2. If the adverse benefit determination is based on medical necessity or experimental or investigational exclusion or limit, explanation or statement of scientific/clinical judgment must be provided to person; 3. Statement indicating that person may have other voluntary alternative dispute resolution options. Person should be referred to appropriate organization, if available. 	
14VAC5-216-70 C	All notices of adverse benefit determination	<p>All notices must be linguistically and culturally appropriate. Carriers must:</p> <ul style="list-style-type: none"> 1. Provide consumer assistance services orally in any applicable non-English language 2. Provide any notice in applicable non-English language, upon request 3. Include in all English versions of notices, a statement in applicable non-English language indicating how language services can be accessed <p>Note: A non-English language is applicable if 10% or more of the population (in the city or county where the notice is sent) is literate only in the same non-English language.</p>	
14VAC5-216-70	Notice of benefit determination following appeal	Written or electronic notice of determination is required to be provided to covered person.	

PART 3 - DRUG EXCEPTION REQUESTS (Health carriers)

REFERENCES	WHEN REQUIRED	WHAT	DOCUMENT NAME/ PAGE #/ SECTION #
14VAC5-216-65 §38.2-3407.9:01	If a health carrier has a closed formulary (excludes coverage for drugs not in its prescription drug formulary)	<ul style="list-style-type: none"> ○ Carrier must have a process for the covered person to receive clinically-appropriate drugs that are not included on the health benefit plan formulary and not otherwise covered. <ul style="list-style-type: none"> ○ Allow the enrollee to obtain without cost-sharing beyond that of formulary drugs a medically necessary non-formulary drug: <ul style="list-style-type: none"> ▪ If the carrier determines the formulary drug is an inappropriate therapy for the enrollee; or ▪ If the covered person received that drug for at least 6 months prior to the carrier changing the formulary, and the prescriber considers the formulary drug to be an inappropriate therapy or represents a significant health risk; ○ Carrier must act on the request within one business day of receipt. ○ A standard exception request must be acted upon within one day of receipt; <ul style="list-style-type: none"> ▪ A determination must be provided to the person and prescriber within 72 hours of receipt (individual and small group non-grandfathered plans only). ○ For exigent circumstances, a coverage determination of an expedited exception request must be provided to the covered person and prescriber within 24 hours following receipt (individual and small group non-grandfathered plans only). ○ If the internal request is denied, the covered person or prescriber may request from the carrier an external exception request in which an IRO reviews the original exception request and subsequent denial. A determination on the external exception request must be made within the same standard or expedited timeframes as was required for the original drug exception request (individual and small group non-grandfathered plans only). ○ If coverage of the non-formulary drug is granted through the internal or external standard exception request process, the drug must be covered for the duration of the prescription (including refills). If coverage is granted through the internal or external expedited exception request process, the drug must be covered for the duration of the exigency. (Individual and small group non-grandfathered plans only) ○ The drug must be covered as if the drug is part of the formulary. ○ Carrier must contract with at least one accredited IRO to perform the external exception request (individual and small group non-grandfathered plans only). 	

PART 4 - REPORTING AND DATA MAINTENANCE REQUIREMENTS (Health carriers)

REFERENCES	WHEN REQUIRED	WHAT	DOCUMENT NAME/ PAGE #/ SECTION #
§ 38.2-5804 A 1 § 38.2-511	Maintain for no less than 5 years	<ul style="list-style-type: none"> • Documentation to support that MCHIP will maintain complete record of written complaints from the policyholder/subscriber or claimant for no less than 5 years, including: <ul style="list-style-type: none"> ○ Total number of complaints; ○ Classification by line of insurance; ○ Nature of each complaint; ○ Disposition of complaints; ○ The time it took to process each complaint. 	
§ 38.2-5804 C	By March 31	<ul style="list-style-type: none"> • Each MCHIP carrier must maintain and submit an annual complaint report to the Office of the Managed Care Ombudsman and State Health Commissioner by March 31. It must include: <ul style="list-style-type: none"> ○ Description of procedures of complaint system; ○ Total number of complaints handled; ○ Disposition on the complaints; ○ Compilation of the nature and causes of complaints; ○ Time it took to process complaints; ○ Number, amount, and disposition of malpractice claims during the year with respect to any affiliated providers. 	
§38.2-3568 B	By April 1	<ul style="list-style-type: none"> • Health carriers shall keep written records of external reviews for at least 3 years. • Health carriers must submit a report to BOI by April 1st for the preceding year to include: <ul style="list-style-type: none"> ○ Total number of requests for external review; ○ Number of requests determined eligible for external review; ○ Number of external reviews completed; ○ Other information required by BOI. 	

PART 5 – DENTAL AND STAND-ALONE VISION MCHIPs

NOTICE REQUIREMENTS

REFERENCES	WHEN REQUIRED	WHAT	DOCUMENT NAME/ PAGE #/ SECTION #
§ 38.2-5803 A 14 VAC5-211-210	At time of enrollment or time EOC is issued, and available upon request or at least annually	<ul style="list-style-type: none"> • Information must include: <ul style="list-style-type: none"> • Description of method to resolve enrollee complaints (for HMOs, must be included in EOC). • Required language (§38.2-5803 A 5). • Contact information for the Office of Managed Care Ombudsman: telephone, email, mailing address. <p>Note: Approval of the EOC form is a separate function within the Bureau. Approval of the complaint system filing does not constitute an approval of the EOC or any documents subject to filing and approval requirements pursuant to §§ 38.2-316 and 38.2-4306 of the Code of Virginia.</p>	
§ 38.2-5804 A 2	With adverse benefit determination and upon request	<p>MCHIPs must provide complaint forms and/or written procedures that include:</p> <ul style="list-style-type: none"> • Address and phone number of MCHIP department or contact person to which/whom complaints are to be directed; • Mailing address, telephone number and e-mail address of the Office of the Managed Care Ombudsman; • Required time limits/deadlines for filing complaints/appeals; 	

REPORTING AND DATA MAINTENANCE REQUIREMENTS

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§ 38.2-5804 A 1 § 38.2-511	Maintain for no less than 5 years	<ul style="list-style-type: none"> • Documentation to support that MCHIP will maintain complete record of written complaints from the policyholder/subscriber or claimant for no less than 5 years, including: <ul style="list-style-type: none"> ○ Total number of complaints; ○ Classification by line of insurance; ○ Nature of each complaint; ○ Disposition of complaints; ○ The time it took to process each complaint. 	

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