Notice of Grievance Procedures

State of Missouri

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

In Writing:	Quality Control P.O. Box 82657 Lincoln, NE 68501-2657
By Phone:	877-897-4328 (Toll-Free)
By Facsimile:	402-309-2579

Also, you always have the right to contact the Missouri Department of Insurance if you have a question or concern regarding your coverage under this contract. The Missouri Department may be contacted:

In Writing:	Missouri Department of Commerce and Insurance 301 West High Street Jefferson City, Missouri 65101
By Phone:	800-726-7390

You also have the right to ask a relative, friend, lawyer, the Department of Insurance or other representative to assist you in filing a grievance, review its decisions involving your requests for service, or your requests to have your claims paid. You have the right to request through our Quality Control Department a written statement of the clinical rationale relied upon in making any adverse determinations, as defined below.

I. Definitions

"Adverse Determination" means a determination made by us that a claim for a proposed or given health care service has been reviewed and, based upon the information provided, does not meet our requirement for medical necessity or appropriateness and, therefore a benefit is denied, reduced or terminated.

"Grievance" means a written complaint submitted by or on behalf of an enrollee regarding the availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review, claims payment, handling, or matters pertaining to the contractual relationship between an enrollee and us.

"Utilization Review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings.

II. Levels of Review

Reconsideration – A treating provider has the opportunity to request, on your behalf, reconsideration of an adverse determination. A reviewing provider will conduct the reconsideration discussion within one working day of the request. The reviewing provider will either be the reviewer who made the adverse determination or a clinical peer if the original reviewer is not available in the required timeframe. If the reconsideration process does not resolve the difference of opinion, the appeal process is available.

The following levels of review will be available to an enrollee or provider acting on behalf of the enrollee.

First Level Grievance Review - for written grievances, including those resulting from an adverse determination.

Second Level Grievance Review - following first level reviews if grievance not resolved.

Expedited Review - only for adverse determinations of emergency requests.

A. First Level Grievance Review

A written grievance concerning any matter, including an adverse determination, may be submitted by an enrollee. First level reviews of an adverse determination will be conducted by a clinical peer. Any first level review will not be reviewed by the same person or persons who made the initial determination denying a claim or handling the matter that is the subject of the grievance. Upon receipt of a request for a first level grievance review, we shall acknowledge receipt in writing of the grievance within ten working days. We will conduct a complete investigation of the grievance within twenty working days after receipt of the grievance. If the investigation cannot be completed within the twenty working days after receipt of the grievance, the enrollee will be notified in writing on or before the twentieth working day and the investigation shall be completed within thirty working days thereafter. The notice will set forth the reasons for which additional time is needed for the investigation.

Within five working days after the investigation is completed, someone not involved in the circumstances giving rise to the grievance or its investigation will decide upon the appropriate resolution of the grievance and notify the enrollee in writing of the decision and of their right to file an appeal for a second level review.

Within fifteen working days after the investigation is completed, we will notify the person who submitted the grievance of our resolution.

B. Second Level Grievance Review

Upon receipt of a request for a second level review for any grievance not involving an adverse determination, we shall submit the grievance to a grievance advisory panel, which consists of other enrollees and plan representatives who were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance.

Any second level review will not be reviewed by the same person or persons who made the initial determination denying a claim or handling the matter that is the subject of the grievance. Second level reviews of an adverse determination will be conducted by a clinical peer.

Any second level grievance review will follow the same time frames as a first level review.

C. Expedited Review

If the time frame of the standard grievance procedures would seriously jeopardize the life or health of an enrollee, an expedited review may be requested. A request for an expedited review may be submitted orally or in writing. However, the request shall not be considered a grievance unless the request is submitted in writing. Expedited review procedures shall be available to an enrollee, the representative of an enrollee and to the provider acting on behalf of the enrollee.

We will notify an enrollee orally within seventy-two hours after receiving a request for an expedited review of our determination. We will provide written confirmation of our decision covering an expedited review within three working days of providing notification of the

determination. Expedited reviews of an adverse determination will be reviewed by clinical peers in the same or similar specialty as would normally manage the case under review. These clinical peers will not have been involved in the initial adverse determination.

An expedited review is not available for retrospective adverse determinations.

III. Written Decision

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

1. a statement of the reviewer's understanding to the grievance;

2. the decision stated in clear terms and the contract basis or medical rationale supporting the decision, a reference to the evidence or documentation used as a basis for the decision;

3. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, provide the enrollee and their designated representative with either the specific rule, guideline, protocol, or other similar criterion or a statement that such rule, guideline, protocol or other criterion relied upon in making the adverse determination. A copy of such will be provided free of charge to the enrollee and their designated representative upon request;

4. for first level reviews, a description of the process to obtain a second level grievance review and the time frame for review.

5. notice of the enrollee's right to contact the Missouri Department of Commerce and Insurance.