Notice of Grievance Procedures

In accordance with Louisiana Laws Statutes Title 22 – Insurance

Please read this notice carefully to learn important information about how to file grievances with us. You have the right to ask us to assist you in filing a grievance or to review our decisions involving your requests for benefits. You may contact us at the following address:

Quality Control
P.O. Box 82657
Lincoln, NE 68501-2657
877-897-4328 (Toll Free)
Fax 402-309-2579

I. Definitions

"Adverse Benefit Determination" means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit. Such determination can be based on eligibility or utilization review, including a determination that a service is not medically necessary or appropriate.

"Grievance" means a written complaint or, if the complaint involves an urgent care request, an oral complaint, submitted by or on behalf of a covered person regarding:

(a) the availability, delivery, or quality of health care services, including an adverse determination made pursuant to utilization review.
(b) benefits or claims payment for health care services.
(c) matters pertaining to our contractual relationship.

"Utilization Review" means a system of reviewing the medical necessity, appropriateness, or quality of health care services and procedures using specified guidelines, the application of practice guidelines and retrospective review.

II. Levels of Review

The following levels of review will be available to you and/or your authorized representative.

A. Internal Level Grievance Review

A written grievance concerning any matter, or an oral complaint involving an urgent care request, including an adverse determination may be submitted by you or your authorized representative, within 180 calendar days of receipt of the adverse determination.

You have the right to receive upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claim for benefits and to submit comments and documents relating to the claim, without regard to whether that information was submitted or considered in the initial benefit determination, and to receive continued coverage pending the outcome of the appeals process where required by applicable law or the plan document or policy.

We will send a written decision to you and your authorized representative no later than thirty (30) calendar days after receiving a request for internal level review. In an adverse determination involving medical necessity or appropriateness, the review of an adverse determination will be conducted by a clinical peer other than the Person or Persons who made the initial determination on the matter.

B. External Review

All internal grievance processes should be exhausted prior to requesting an external review of an adverse determination for dental claims in excess of two hundred fifty dollars ($250). You may have the right to have our decision reviewed by health care professionals who have no association with us. In order to request an external appeal, you should send your request in writing to our office at the designated address included in this notice within four months after the date of receipt of an adverse determination or final adverse determination. **You or your authorized representative may submit additional information with your request.**

Within five business days following the date of receipt of the external review request, we will complete a preliminary review of the request and notify you and/or your authorized representative and the commissioner that the review is complete, and the request is eligible for external review. If the request is not complete, we will inform you and/or your authorized representative in writing what information or materials are needed to make the request complete. If your request is not eligible for external review, we will notify you and/or your authorized representative in writing why the request is ineligible.

You or your authorized representative may file a request for external review and will be considered to have exhausted our internal grievance process if we have not issued a written decision no later than 30 days after the date of the filed grievance, and you or your authorized representative have not requested or agreed to a delay.

When filing a request for an external review, you will be required to authorize Us and your treating health care provider to disclose protected health information, including the release of any medical records that are pertinent for the review of the adverse determination. You or your authorized representative may submit additional information that would assist in the review. No fee or any other charge will be levied upon a covered person for any costs of an external review.

Upon receipt of notice of a decision made by an independent review organization reversing our original determination, we will immediately approve the coverage or payment.

C. Expedited External Review

If the Covered Person has a medical condition where the time frame for completion of an expedited review of a grievance involving an adverse determination would seriously jeopardize the life or health or the Covered Person's ability to regain maximum function, the covered person or authorized representative may file a request for an expedited external review.

Further, an expedited external review is available if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Covered Person's provider certifies in writing that any delay in appealing the adverse determination may pose an imminent threat to the Covered Person's health including but not limited to severe pain, potential loss of life, limb, or major bodily function, or the immediate deterioration of the health of the covered person.

You or your authorized representative may simultaneously (1) file a request for an expedited external review of a grievance involving an adverse determination, and (2) file the grievance under our internal expedited grievance process, but the assigned independent review organization shall determine whether the Covered Person or their authorized representative will be required to complete the expedited review of the grievance before conducting the expedited external review.

Immediately upon receipt of the request for an expedited external review, we will determine whether the request meets the reviewability requirements and immediately notify the Covered Person or their

authorized representative of our eligibility determination. If we determine your request is ineligible, that decision may be appealed to the Commissioner of the Louisiana Department of Insurance.

If we determine your request is eligible for expedited external review, we will submit a request for assignment of an independent review organization. The Commissioner of the Louisiana Department of Insurance will immediately notify us of the assigned organization. Upon receipt, we will provide or transmit all necessary documents and information considered in the adverse determination or final adverse determination to the assigned independent review organization electronically, by telephone or facsimile, or by any other available expeditious method.

As expeditiously as the Covered Person's medical condition or circumstances requires, but in no event more than seventy-two hours after the date that we received the request, the assigned independent review organization shall make a decision to uphold or reverse the adverse or final adverse determination and notify the Covered Person and if applicable, their authorized representative, us, and the Commissioner of the Louisiana Department of Insurance.

Upon receipt of notice of a decision made by an independent review organization reversing our original determination, we will immediately approve the coverage or payment.

An expedited external review shall not be provided for retrospective adverse determinations or retrospective final adverse determinations.

You always have the right to contact the Department of Insurance. The Office of Consumer Services is available to assist you with the appeal process.

Louisiana Department of Insurance
P.O. Box 94214
Baton Rouge, LA 70804
(225) 342-5900
800-259-5300
www.ldi.la.gov

III. Cultural and Linguistic Support

We want to be sure this information is helpful to you. We are sending it in a culturally and linguistically appropriate manner as described in the Affordable Care Act and 45 CFR 147.136 (e). We can provide interpreting services through our toll-free Customer Service line shown in Section III. For Spanish only, you may call 1-800-487-5553 and speak directly to an employee who is proficient in the Spanish language. Upon request, we will provide certificates of coverage and provider directories in Spanish, or large print materials for the visually impaired. We are prepared to help hearing impaired members who access TDD or TTY "text telephone" systems when contacting us.