

Health Insurance Grievances and Complaints

Most people will never have a problem with their health [insurance](#). But when you have a complaint about your plan, it is important to understand the steps you must take to resolve your problem.

This publication serves as a guide to help you understand the [grievance](#) and complaint process that all [policies](#) sold in Wisconsin are required to offer you. Included at the end of the publication is a series of worksheets to help you document your complaint process.

Although most health plans have an [appeal](#) process, not all health plans are subject to the appeal process discussed in this publication. If your plan is self-funded by your employer, it is subject to federal, not state law. Public programs like Medicare and Medicaid also have their own appeal processes. You will have to contact your employer or the Medicare and Medicaid programs directly for information about their grievance processes.

What You Need to Know About Your Health Plan

How do I receive medical benefits from my health plan?

Most health plans require you to follow certain procedures in order to receive [coverage](#) from the plan. If you know the procedures your health plan requires and follow them, you will be less likely to have problems when you need services. For example, you should know how to file a [claim](#), when you might need [prior authorization](#) from your plan, when you need to contact the company, and who your [in-network providers](#) are. Familiarize yourself with these procedures before you need health care to minimize trouble when you are already dealing with health problems.

Is your provider in-plan?

If you are in a [managed care plan](#), make sure your provider is in-plan before each visit to ensure you will receive coverage. Some plans allow you to receive services from non-plan providers; however, you will pay a larger portion of the bill. Some plans may also have more than one benefit level for in-plan providers; for example, a visit to a specialist may require a higher [copay](#) than a visit to a [primary care provider](#). Make sure you understand what you will be required to pay. You may verify this by checking the plan's website or by calling your insurer.

What is covered and what is excluded under my health plan?

You should review your summary of benefits and coverage for a quick overview of the procedures and medications, but your certificate of coverage will provide a complete picture of your coverage including [exclusions](#) and limitations.

What if my plan does not cover something?

No health plan covers everything—sometimes not even health care services that are medically necessary or procedures where there is no other option. However, remember as a consumer you may ask your insurer to cover your procedure if you believe it is an effective treatment. You may ask the insurer to consider covering the procedure on an exception basis if you believe it is more effective than a covered procedure.

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

Office of the Commissioner of Insurance, 101 E. Wilson Street, P.O. Box 7873, Madison, WI 53707-7873 p: 608-266-3585 | p: 1-800-236-8517 | f: 608-266-9935 | ocicomplaints@wisconsin.gov | oci.wi.gov

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Where do I find answers to these questions?

Review your member material, including your policy or certificate and provider directory. For coverage of prescription drugs, check your plan's [formulary](#). These documents may generally be found on the health plan's website.

You may also call your health plan's customer service number for this information. If your plan is employer-based, you may talk to your employer's human resources section to find answers.

Most importantly, make sure to keep all records. In addition to the information on the plan's website, keep copies of any correspondence from your insurer, letters from providers and/or other documents such as medical records and test results, and records of all phone calls made to your health plan. The attached worksheets are included to help you document conversations with your insurer.

What if coverage is denied?

If your plan denies your claim or your request for coverage, you will receive a written notice. This denial notice (or explanation of benefits) should explain why your insurer denied your claim. Your health plan should give you a specific reason for the denial. The notice should also explain your appeal rights.

What should I do if I have a complaint?

Many [complaints](#) or questions may be resolved informally by calling your plan's customer service line. Many health plans also have websites that can be helpful in resolving your complaints. If you have questions regarding how to complain to your insurer, call OCI at 800-236-8517 or visit oci.wi.gov/complaints for help filing a complaint.

What if I'm not satisfied with the results of my complaint?

You still have the right to file a grievance. Your denial notice may explain how to do this or tell you how to find these instructions. The denial notice also includes information about your right to have your claim reviewed by an [Independent Review](#) Organization.

What is a grievance?

A [grievance](#) is any written dissatisfaction with the provision of services, claims practices, or the administration of a health benefit plan. You or someone you authorize may submit the grievance on your behalf. For example, a grievance can be filed when your health plan denies your request for a referral, your health plan will not cover a treatment you believe you need, or you are dissatisfied with the quality of the treatment provided by your [network physician](#).

In some cases, you may need to resolve your grievance more quickly than the standard grievance process. If this is the case, request an expedited grievance. An expedited grievance means a grievance where any of the following apply:

- The length of time for a normal grievance resolution would result in serious jeopardy to your life or health or would limit the ability for you to regain maximum function.
- Your physician requests the expedited process because your pain is too severe to be adequately managed without the care or treatment you are requesting.
- Your physician determines the grievance should be treated as an expedited grievance.

How do I file a grievance with my health plan?

You may file a grievance by sending a letter to your health plan. Keep the following points in mind when writing and sending your letter:

- Identify yourself, including your name, address, and health plan ID number.

- Explain the problem; be specific with dates of service, denial notice, summaries of any phone conversations, and why you believe the plan's decision is wrong.
- Base your argument on policy language; if you are asking for an exception, explain how coverage could benefit the plan—such as avoiding a more expensive treatment that is covered.
- Clearly state what you want the resolution of your grievance to be.
- Include photocopies of any supporting documents, such as medical records, [referrals](#), supporting letters from doctors, and articles from peer-reviewed medical journals. If your grievance involves a medical issue, you may want to talk to a doctor and ask if they have any records supporting your position.
- Keep the letter business-like.
- If someone else is sending the grievance for you, include a note signed by you authorizing that person to act on your behalf; most plans will require this.
- Send the letter to the address provided on the denial notice or in your certificate.

What happens next?

Your health plan must send you an acknowledgment within five business days of receiving your letter. If you do not receive an acknowledgment, call your plan. Some plans may review the grievance to try to resolve the problem informally.

Can I be present at the grievance review?

Yes, but you are not required to attend. Your health plan must send you a notice of the time and place of the meeting at least seven days in advance. You have the right to appear in person or by teleconference before the grievance panel where you may present written and oral information and question the decision makers.

The grievance panel must include at least one individual authorized to take corrective action, one insured who is not part of the plan, if possible, and may not include the person who made the initial determination. The panel is not required to include a medical professional but should consult one when appropriate.

When can I expect to hear from my health plan?

Your plan should send you a grievance resolution letter within 30 days of initially receiving the grievance. In some cases, the plan may need to extend the decision an additional 30 days but must send you a written notice explaining the reason for the extension.

When you do receive a response, it will be in the form of a letter either accepting or denying your grievance. If your grievance was denied, the letter should explain any additional options, including the right to an independent review. The letter should be signed by one voting member of the panel and include the titles of the panel members.

Independent Review Process

Both state and federal law give individuals the right to request an independent external review when their health plan denies or reduces coverage of medical services in some circumstances. Although the laws are similar, there are some significant differences. This publication provides general information on Wisconsin's process.

What is an independent review?

An independent review is a process in which an outside expert provides a second look at your claim. Because the reviewer is not affiliated with you, your medical provider, or the insurer, the reviewer can conduct an independent and unbiased review of your claim.

The independent review process is intended to be an easy way to allow you to receive an independent decision within a relatively short time frame. You may request an independent review whenever your health plan denies you

coverage for treatment based on a medical judgment. For example, you may request an independent review if the health plan maintains that the treatment is not medically necessary according to the definition in your policy or if the treatment is experimental. You may not request an independent review if the requested treatment is not a covered benefit in your health plan.

Who performs the independent review?

The independent review process provides you with an opportunity to have your dispute reviewed by experts who have no connection to you, your medical provider, or your health plan. The independent review organization (IRO) assigns your dispute to a clinical peer reviewer who is an expert in the treatment of your medical condition. The clinical peer reviewer is generally a board-certified physician or other appropriate medical professional. In some cases, the IRO will also consult with an attorney or other insurance expert.

When can I request an independent review?

You can request an independent review whenever your insurer bases its decision to deny coverage on a medical judgment. In most cases, you cannot request an independent review until you have completed the internal grievance process but may bypass this process if both you and the insurer agree or the IRO agrees a delay in receiving care could jeopardize your health. The independent review must be requested within four months of the date listed on your grievance resolution letter.

How do I request an independent review?

The grievance resolution letter should explain how to request an independent review. Send your request for an independent review to the address provided in the insurer's final written decision letter.

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 (photocopies);
- if someone else is filing on your behalf, a statement signed by you authorizing that person to be your representative; and
- any other information requested by your insurer.

After your insurer receives the information, it must send all relevant medical records and other documentation used in making its decision to the IRO within five business days. The IRO then has five business days to review the information and to request any additional information it may need from the insurer or from you.

Then what will the IRO do?

First, the IRO will review the request to verify it has no connection to the insurer or health care provider. Then the IRO will review the file to determine if it is complete. You or your insurer may be asked for additional information.

When the IRO has all the information it needs, it has 30 business days to decide. The file is forwarded to a clinical peer reviewer who has relevant expertise. In reviewing a case involving medical necessity, the IRO and its reviewer are required to consider all documentation, including your medical records, your attending provider's recommendation, the terms of coverage of your health plan, the rationale for the insurer's prior decision, and any medical or scientific evidence. It must limit its decision on a case involving experimental treatment to whether the proposed treatment is experimental. The IRO will send its decision letter to you and your insurer after 30 days.

Federal external review process:

Most health plans in Wisconsin are required to follow the federal external review process. Under the federal process, insurance companies may choose to participate in an external review process administered by the U.S.

Department of Health and Human Services (HHS) or to follow the external review process regulations developed by the U.S. Department of Labor (DOL).

HHS has contracted with Maximus Federal Services, Inc., to provide independent external reviews under the HHS-administered process. Information on this process is available at externalappeal.cms.gov or by calling 1-888-866-6205 ext. 3326.

Health plans following DOL's external review process must privately contract with at least three nationally accredited IROs. When you send your review request to the health plan, it must have a process to randomly choose one of its contracted IROs for an external review.

What if I need medical attention now?

If you believe you need treatment urgently and waiting 30 days for the IRO to complete the standard independent review process could jeopardize your health or life, you may be eligible for an expedited process.

Send your request to both your insurer and the IRO at the same time. The IRO's medical staff will then review your request and has the authority to determine if the grievance process may be bypassed. You will be given a decision within 72 hours.

Do I have any other options?

If you have already gone through the grievance process and are still unsatisfied with the results, you may:

- File a complaint with OCI.
- Hire an attorney.
- Take your complaint to small claims court.
- Contact your employer's human resources department for assistance.

Other Resources

Employer Self-funded Complaints

The U.S. Department of Labor regulates employer self-funded health plans. You may file a complaint or submit a question by contacting them at dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa or by calling 1-866-444-3272.

Medicare Complaints

The Centers for Medicare and Medicaid Services (CMS) has jurisdiction over the Medicare program. Information about the Medicare complaints and appeals processes is available at medicare.gov/claims-and-appeals/file-a-complaint/complaint.html.

Wisconsin Medicaid (BadgerCare Plus) Complaints

The Wisconsin Department of Health Services (DHS) administers the Wisconsin Medicaid program. Information about DHS' complaint processes is available by calling their toll-free number, 1-800-362-3002.

Disclaimer

This guide is intended as a general overview of current law in this area but is not intended as a substitute for legal advice in any particular situation. You may want to consult your attorney about your specific rights. Publications are updated annually unless otherwise stated and, as such, the information in this publication may not be accurate or timely in all instances. Publications are available on OCI's website at oci.wi.gov/Publications. If you need a printed copy of a publication, use the online order form (oci.wi.gov/Pages/Consumers/Order-a-Publication.aspx) or call 1-800-236-8517. One copy of this publication is available free of charge to the general public. All materials may be printed or copied without permission.

Can I change my primary-care physician if I want to?

Do I need to get permission before seeing a medical specialist?

What are the procedures for getting care and being reimbursed in an emergency, both at home and out of town?

If I have a chronic medical condition, how will the plan treat it?

Are my prescription medications covered by my health plan?

If I want alternative medical therapies such as acupuncture or chiropractic treatment, will they be covered by my health plan?

Are all pregnancy-related medical costs covered by the provider?

Step 2: Keep your records

In the event you may have a complaint in the future, it is important to keep all records relating to your insurance policy.

Policy certificate (generally available on your health plan’s Web site)

Medical records/test results

Letters from providers

Records of all phone conversations, including:

Date and time: _____

Number called: _____

Name of the plan representative: _____

Summary of the discussion (including any promises made and the estimated time for any payment resolution):
