Instructions for Grievance Form 26-007

Health insurers are required to file annual grievance reports by March 1 of each year.

Things you'll need before completing the Annual Grievance Report (OCI 26-007)

1. Your company's product type(s)
2. Structure of your company's Grievance Committee or Panel
3. Social media used by your company
4. Independent review organization(s) (IRO) used by your company
5. Your company's grievance log
6. Your company's Average Monthly Enrollment
7. Your company's Total Policies Written
8. Your company's Direct Premium Earned
9. SERFF Filing Number and Submission Date for most recent submission for each product type

Tips to assist in completing the Annual Grievance Report

1. Use Chrome browser.
2. The maximum number of attachments is 20 with a maximum size of 5 MB each.
3. This form has multiple pages. When you click "Next", you may need to scroll to the top of the page.
4. This application will time out when the application has been inactive for 120 minutes. The application may close without notice if you have not entered any data for 120 minutes, so you should use the "Save and Finish Later" feature if you need to obtain additional information.
5. A blank copy of the Annual Grievance Report form is attached to these instructions as a sample.
6. A blank copy of the standardized Grievance Log and additional reporting Guidance are available on OCI's website at https://oci.wi.gov/Pages/OCIForms/26-007Intro.aspx.
7. If your company no longer has any active business in a product type that it has been assigned and does not plan to begin marketing that product type, please contact us at the email below so that we can update our records.
8. For the purpose of the grievance reporting form, HBPs include all health insurance policies not considered HMOs, LSHOs, Med Supp, or PPPs. Dental-only and vision-only PPPs are considered HBPs for grievance reporting purposes.
9. The HMO Product Type in this form should include grievances related to point-of- service business and exclusive-provider-organization (EPO) business.
10. The HBP Product Type in this form should include dental-only and vision-only plans that are not issued by LSHO insurers, and also include limited benefit and short-term plans.
11. Below is information related to the "Number of Grievances by Category" data fields in the form.

    a. The explanation of the grievance categories is attached to these instructions and is also included in the reporting form.
    b. The reporting form application automatically totals the number of grievances from the category list according to the column titled "Type" and fills in the totals in the chart on the next page.
    c. When more than one category could apply to a grievance:
        i. Choose Out-of-Network over Prior Authorization or Plan Providers.
        ii. Choose Not Medically Necessary over Prior Authorization.

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iii. Choose Preventive over Cost-sharing.

Definitions

Grievance - any written dissatisfaction with the provision of services or claims practices of an insurer that is expressed to the insurer by, or on behalf of, an enrollee.

Grievant – individual that filed the grievance. This may be an insured or another individual who filed the grievance on behalf of the insured, such as a parent or other relative, a health care provider, or another representative of the insured.

Resolution Code "Approved" - original decision overturned or otherwise resolved as grievant requested.

Resolution Code "Denied" - original decision or company position upheld.

Resolution Code "Compromise" - original decision partially overturned.

Resolution Code "Withdrawn" - grievant requests grievance be withdrawn prior to company beginning its investigation.

Average Monthly Enrollment- average monthly number of covered lives (including dependents) for all in-force policies during all or part of the current reporting year.

Total Policies Written - number of new policies issued during reporting year.

Direct Premium Earned - the portion of premium for which the policy coverage has already been given during the current reporting year. Note: do not include Medicaid premium.

A blank copy of the standardized Grievance Log and additional reporting Guidance are available on OCI's website at https://oci.wi.gov/Pages/OCIForms/26-007Intro.aspx.

For questions or assistance, please send an email to: ocimrreports@wisconsin.gov.

Standardized Grievance Log

Instructions for filling out the grievance log.

1. Column A ID# - This is a free-form cell. It is a unique identifier used by the company to identify the grievance file. It should not include the person's name or any other personally identifiable information.
2. Column B OCI Complaint? – This is a Yes/No option for whether the grievance is on file with OCI (whether it was received directly from OCI or sent to OCI in addition to the company).
3. Column C Source of Grievance – This response is limited to:
    a. If received directly from the insured member, choose Insured
    b. If received from a provider on behalf of the insured member, choose Provider
    c. If received from another individual on behalf of the insured member, choose Authorized Representative
    d. If OCI requests that an OCI complaint be reviewed as a grievance, choose OCI.
4. Column D Plan Type – This response is limited to EPO, HMO, POS, PPP, MSP, LSHO, Dental, Vision, Limited Benefit, Short Term or HBP.
5. Column E Date Received – This is the date the grievance was received by the company. Please note – if the grievance is received by the wrong department and forwarded to the grievance department, it does not delay this date. The clock starts when the company first receives it.
6. Column F Expedited? – This is a Yes/No option. The response should be "Yes" if the grievance was expedited or "No" if reviewed under the standard process. 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.
7. Column G Date of Acknowledgement Letter – This is the date the company notified the grievant that their grievance had been received.
8. Column H Meeting Notice Date – This is the date the company notified the grievant of the date and time of the grievance meeting. Note: this may be the same date as Column G.
9. Column I Meeting Date – This is the date that the grievance meeting was held. If the meeting is postponed for any reason, this cell should reflect the date the meeting was held, and not the original date it was scheduled.
   Note: If there was no meeting because the grievance involved a prescription drug formulary exception request reviewed pursuant to 45 CFR § 156.122, the response is "exempt"
10. Column J Date Resolved – This is the date when the final notice was sent to the grievant.
11. Column K Extension Requested? – This is a Yes/No option for whether, because of an unexpected delay in the resolution, an extension was requested.
12. Column L Grievance Category – This cell response is limited to one of the 3-character Category Codes from the Annual Grievance Report.
13. Column M Category Qualifier – This is a free-form cell for a short descriptor of the type of service that is being appealed. Some examples of these descriptors are provided in the Note attached to the column header. Although this is free-form, please limit answer to 25 characters or less if possible.
    a. The qualifier should describe the specific medical service requested or the insured's medical condition. It should not repeat or paraphrase the name of the grievance category.
    b. If the grievance relates to a formulary exception request under 45 CFR § 156.122, use the

category qualifier “”Formulary – ACA”.

c. For grievances involving contraceptive services, the category is PVS; the category qualifier should be “Contraceptive Services.”
d. For grievances involving coverage of mental health/substance use disorder services, the category qualifier should be “Mental Health”.

14. Column N Resolution Code – This cell response is limited to Approved, Denied, Compromise or Withdrawn.
15. Column O Resolution Qualifier – This is a, free-form cell for a short descriptor of the resolution. Some examples of these descriptors are provided in the Note attached to the column header. Although this is free-form, please limit answer to 25 characters or less if possible. NOTE: beginning with coverage year 2024, this column is mandatory.

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