H-3850.1

HOUSE BILL 2619

State of Washington 54th Legislature 1996 Regular Session

By Representatives Cody, Murray, Conway and Dellwo

Read first time 01/15/96. Referred to Committee on Health Care.

AN ACT Relating to grievance procedures; and adding a new chapter to Title 70 RCW.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** This chapter may be known and cited as the grievance procedure act.

NEW SECTION. **Sec. 2.** The purpose of this chapter is to provide standards for the establishment and maintenance of reasonable procedures by health carriers in order to assure that covered persons have the opportunity for the equitable resolution of their grievances dealing with health care services, claim payments and handling, and other complaints. This chapter does not create an administrative procedure necessary for exhaustion before exercising other remedies available to a covered person under state law. While the state might want to encourage the use of alternative dispute resolution procedures as a form of resolving contractual disputes, commissioners should ensure that health benefit plans do not include provisions imposing binding arbitration on covered persons unless the provisions are required by other state statutes.

NEW SECTION. **Sec. 3.** Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Adverse determination" means a determination that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the requirements for medical necessity, appropriateness, level of care, or effectiveness.

(2) "Clinical peer" means a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.

(3) "Closed plan" means a managed care plan that requires a covered person to use a participating provider under the terms of the managed care plan.

(4) "Commissioner" means the insurance commissioner.

(5) "Covered person" means a person entitled to receive benefits or services under a health benefit plan.

(6) "Emergency" means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention and that failure to provide the medical attention would result in serious impairment to bodily function or permanent dysfunction to a bodily organ or part, or would place the person’s health in serious jeopardy.

(7) "Facility" means an institution providing health care services or a health care setting, including but not limited to a hospital and other licensed inpatient center, ambulatory surgical or treatment center, skilled nursing center, residential treatment center, diagnostic, laboratory, and imaging center, and rehabilitation and other therapeutic health setting.

(8)(a) "Grievance" means a written complaint submitted by or on behalf of a covered person regarding the:

(i) Availability, delivery, or quality of health care services;

(ii) Claims payment, delivery, or quantity of health care services; or

(iii) Another matter pertaining to the contractual relationship between a covered person and the health carrier.

(b) "Grievance" does not include a complaint regarding a denial of coverage for treatment during a medical emergency while the emergency is occurring.

(9) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse a cost of health care services.

(10) "Health care provider" means a health care professional or a facility.

(11) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(12) "Health carrier" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse a cost of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or another entity providing a plan of health insurance, health benefits, or health services.

(13) "Health indemnity plan" means a health benefit plan that is not a managed care plan.

(14) "Managed care plan" means a policy, contract, certificate, or agreement offered by a health care carrier to provide, deliver, arrange for, pay for, or reimburse a cost of health care services through the covered person’s use of a health care provider or facility managed, owned, under contract with, or employed by the carrier because the carrier either requires the use of or creates incentives, including financial incentives, for the covered person’s use of the provider and facility.

(15) "Open plan" means a managed care plan other than a closed plan that provides incentives, including financial incentives, for a covered person to use a participating provider under the terms of the managed care plan.

(16) "Retrospective review" means utilization review conducted after services have been provided to a patient, but does not include retrospective review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, and adjudication for payment.

(17) "Utilization review" means a set of formal techniques designed to monitor and evaluate the clinical necessity, appropriateness, efficacy, and efficiency of health care services, procedures, providers, and facilities. Techniques may include ambulatory review,

prospective review, second opinion, certification, concurrent review, case management, discharge planning, and retrospective review.

NEW SECTION. **Sec. 4.** (1) A health carrier shall maintain written documentation regarding a grievance containing, at a minimum, the following information:

(a) A category generally describing the reason for the grievance;

(b) Date received;

(c) Date of each hearing;

(d) Resolution, including the written decision, at each level;

(e) Date of resolution at each level;

(f) Name of the covered person for whom the grievance was filed;

(g) Contract and certificate number or other policy information; and

(h) Identity of the providers involved.

(2) The health carrier shall maintain the register in a manner that is reasonably clear and accessible to the commissioner.

NEW SECTION. **Sec. 5.** A health carrier shall retain documentation related to a grievance for the longer of three years or until the commissioner has adopted a final report of an examination that contains a review of the grievance register. A health carrier shall submit, at least annually, a report to the commissioner, on a standardized form adopted by the commissioner.

NEW SECTION. **Sec. 6.** A health carrier shall use written procedures for receiving and resolving a grievance from a covered person.

(1) The health carrier shall file with the commissioner the grievance procedure and all supporting documentation for approval before use. The health carrier also shall file a subsequent modification to the documents with the commissioner, and the commissioner must approve the modification before its use by the health carrier.

(2) The health carrier shall set forth the grievance procedure in or attach the grievance procedure to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to a covered person.

(3) The health carrier shall include in the grievance procedure a statement of a covered person's right to contact the commissioner's office for assistance at any time. The statement must include the telephone number and address of the commissioner.

NEW SECTION. **Sec. 7.** (1) The first-level grievance review committee shall be made up of one or more employees of the health carrier. The committee may not include a person whose decision is being appealed or who made the initial determination denying a claim or handling a grievance. The first-level review must be held within ten working days of receipt of the grievance and all necessary information but not later than twenty working days after receipt of the grievance. The health carrier shall provide to the covered person the name, address, and telephone number of a person designated to coordinate the grievance review on behalf of the health carrier.

(2) A covered person does not have the right to attend or have a representative in attendance at the first-level grievance review. The covered person may submit written material and may have the assistance of an uninvolved member of the health carrier staff. The health carrier shall make these rights known to the covered person sufficiently in advance of the first-level review.

(3) The first-level grievance review committee shall issue a written decision to the covered person or the covered person's representative within five working days from the date of the review. The written decision must contain:

(a) A record of the persons participating in the decision;

(b) A statement of the grievance committee's understanding of the covered person's grievance;

(c) The committee's decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the health carrier's position;

(d) A reference to the evidence or documentation used as the basis for the decision; and

(e) A statement indicating:

(i) A description of the process to obtain a second-level grievance review of an adverse decision; and

(ii) The written procedures governing a second-level review, including a required time frame for review. The health carrier shall provide a minimum of twenty working days to apply for a review.

(4) This section applies to open and closed plans, and to an indemnity plan whether or not the indemnity plan has utilization review procedures.

NEW SECTION. **Sec. 8.** (1) A second-level grievance review panel shall be appointed by the board of directors of the health carrier or the board's authorized representatives. At least one-third of the members of the panel must be covered persons and cannot be the employees or officers of the health carrier or employees' or officers' dependents. However, at the covered person's request, the panel shall be made up only of employees or officers of the health carrier. The panel may not include a person previously involved in the grievance. At least one member of the panel must have actual authority to legally bind the health carrier.

(2) The health carrier shall have written procedures for investigating and conducting a second-level panel review.

(a) At a minimum, the procedures must include the following:

(i) The review panel shall meet at a location reasonably accessible to the covered person within forty-five working days of receipt of the notice requesting a second-level review. The health carrier shall ensure that the review meeting is held during regular business hours. The review panel shall notify the covered person in writing at least fifteen working days in advance of the date and time of the review. A review panel may not unreasonably deny a request for review postponement by a covered person;

(ii) The health carrier shall make the claims file available to a covered person who wishes to pursue a second-level grievance review to assist the covered person in preparing for the review;

(iii) The covered person may attend the second-level panel review and present the covered person's case, and may be assisted or represented by a person of the covered person's choice, including a physician, expert, or other person to present information on the covered person's behalf;

(iv) The covered person may submit written material in support of the covered person's claim together with other information relevant to the dispute; and

(v) The health carrier and review panel may not make the covered person's right to a fair and equitable review conditional on an appearance at the panel review meeting. Regardless of whether or not

the covered person appears, the panel shall conduct the review meeting in the same manner.

(b) At a minimum, the following provisions in this subsection (2)(b) regarding the second-level process apply:

(i) A member of the panel shall make a clear recognition on the member's part that the member's responsibility is to hear and consider impartially the dispute based solely on the material and presentations made during the review process;

(ii) If the health carrier desires to have an attorney present to represent the interests of the health carrier, the health carrier shall notify the covered person at least fifteen working days in advance of the review that an attorney will be present and that the covered person may wish to obtain legal representation of the covered person's own;

(iii) A member of the health carrier staff knowledgeable about the grievance must be present to respond to questions of the panel members and the covered person and to otherwise assist with the complaint review process;

(iv) A panel member and the covered person or the covered person's representative may ask questions of the health carrier, including the health carrier's staff and contracting entities and individuals;

(v) The panel shall render a decision no more than five working days following the review panel's meeting. The panel shall advise the covered person, in writing, of the decision and the reasons underlying it. The panel member possessing legal authority to bind the health carrier shall sign the written notice of decision. The written notice must contain:

(A) A statement of the committee's understanding of the nature of the grievance and all pertinent facts;

(B) The panel's decision and rationale; and

(C) Reference to evidence or documentation considered in making the decision.

(3) This section applies only to a closed plan.

NEW SECTION. **Sec. 9.** (1) A health carrier shall clearly document an adverse determination or noncertification of an admission, continued stay, or service, including the specific clinical or other reason for the adverse determination. The health carrier shall make the determination available to the covered person and the affected provider or facility. The notice to the provider or facility must be issued by

telephone within twenty-four hours of the adverse determination. Written or electronic confirmation must be transmitted to the provider or facility and the covered person within one working day of the adverse decision.

(2) A health carrier shall issue a retrospective review denial in writing within five working days of obtaining all information constituting the adverse determination, and must include the reason for the determination.

(3) A health carrier shall include in the written notice of an adverse determination a description of the appeal procedures and instructions for initiating an appeal.

(4) This section applies to open and closed plans and to indemnity plans that have utilization review.

NEW SECTION. **Sec. 10.** (1) The health carrier shall establish written procedures for a standard and expedited appeal of a decision not to certify an admission, continued stay, procedure, or service. The health carrier shall make the appeal procedures available to the covered person and to the attending or ordering provider.

(2) An appropriate clinical peer in the same or similar specialty as would typically manage the case being reviewed, or another licensed health care professional as mutually agreed upon by the parties, shall evaluate an appeal. An agreement to another licensed health care professional is void if made before the initial determination. The clinical peer may not have been involved in the initial adverse determination.

(3) For a standard appeal, the health carrier shall notify in writing both the covered person and the attending or ordering provider of the decision within thirty working days following the request for appeal.

(4) For an expedited appeal, the health carrier shall make every reasonable effort to process the request within seventy-two hours and to issue a decision no later than one working day following receipt of all necessary information. All parties involved in the appeal shall facilitate this process. An expedited appeal is available only when the standard appeal process would cause a delay in care that could be detrimental to the health of the covered person.

(5) The denial of an expedited appeal may not be the basis for the denial of a subsequent request for approval brought through standard, nonexpedited channels. A subsequent appeal must be de novo.

(6) This section may not be construed to require a covered person or provider to use an expedited appeal in a life-or-limb threatening situation.

(7) This section applies to open and closed plans and indemnity plans that have utilization review.

NEW SECTION. **Sec. 11.** Sections 1 through 10 of this act constitute a new chapter in Title 70 RCW.

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