IF YOU HAVE A COMPLAINT OR AN APPEAL

Definitions

Adverse decision means a utilization review determination by a private review agent, a carrier, or a health care provider acting on behalf of a carrier that: a proposed or delivered health care service covered under the member's contract is or was not medically necessary, appropriate, or efficient; and may result in noncoverage of the health care service; or a denial by a carrier of a request by a member for an alternative standard or a waiver of a standard to satisfy the requirements of a wellness program. An adverse decision includes a utilization determination based on a prior authorization or a step therapy requirement. Adverse decision does not include a decision concerning a subscriber's status as a member.

Appeal means a protest filed by a member, a member's representative, or a health care provider with a carrier under its internal appeal process regarding a coverage decision concerning a member.

Appeal Decision means a final determination by a health plan that arises from an appeal filed with the health plan under its appeal process regarding a coverage decision concerning a member.

Complaint means a protest filed with the Commissioner involving an adverse decision or final adverse decisions, grievance decisions, and coverage decisions concerning a covered person.

Coverage decision means: an initial determination by a carrier or a representative of the carrier that results in noncoverage of a health care service; a determination by a carrier that an individual is not eligible for coverage under the carrier's health benefit plan; or any determination by a carrier that results in the rescission of an individual's coverage under a health benefit plan. Coverage decision includes nonpayment of all or any part of a claim. Coverage decision does not include: an adverse decision involving a medical necessity review or a pharmacy inquiry.

Emergency Case Grievance is defined as a Prospective review and the health services are necessary to treat a condition or illness that, without immediate medical attention, would either 1) seriously jeopardize the life or health of the covered person or the covered person's ability to regain maximum function; 2) cause the covered person to be in danger to self or others; or 3) cause the covered person to continue using intoxicating substances in an imminently dangerous manner.

Filing Date means the earlier of: 5 days after the date of mailing; or the date of receipt.

Grievance means a protest filed by covered person, an authorized representative, practitioner, or health care provider with us through our internal grievance process on behalf of a covered person regarding an adverse decision.

Grievance Decision means a final determination by us that arises from a grievance filed with us under our internal grievance process regarding an adverse decision concerning a covered person.

Health care provider means:
(a) An individual who is:
(i) Licensed or otherwise authorized in this State to provide health care services in the ordinary course of business or practice of a profession, and
(ii) A treating provider of a member; or
(b) A hospital, as defined in Health-General Article, §19-301, Annotated Code of Maryland.

Urgent Medical Condition means a condition that satisfies either of the following:

A) A medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on behalf of a carrier, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:
i) Placing the member's life or health in serious jeopardy;
ii) The inability of the member to regain maximum function;
iii) Serious impairment to bodily function;
iv) Serious dysfunction of any bodily organ or part; or
v) The member remaining seriously mentally ill with symptoms that cause the member to be a danger to self or others; or

B) A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within 72 hours in the opinion of a health care provider with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the coverage decision.

Notification of an Adverse Decision
For nonemergency cases, when an adverse decision is rendered, We will inform You, Your authorized representative, or the Health Care Provider acting on Your behalf of the adverse decision orally by telephone; or with affirmative consent of the Member, the Member's representative, or the Health Care Provider, by text, facsimile, email, an online portal, or other expedited means; and We will send, within 5 working days after the adverse decision has been made, a written notice to the Member, the Member's representative, and the Health Care Provider. The notice will include:

· The name, address, telephone number of the Medical director or associate Medical Director, as appropriate, who made the decision;
· A statement in clear, understandable language the specific factual basis for our decision and the reasoning used to determine that the health care service is not medically necessary and did not meet Our criteria and standards used in conducting the utilization review;
· The reviewers' finding in clear terms and the reason in enough detail for the Member to respond to Our finding;
· The specific reference, language, or requirements from the criteria and standards, including any interpretive guidelines, on which the decision was based. The finding shall include instructions for requesting copies of any referenced evidence, documents or clinical review information not already provided to the Member. Where a Member had already sent in a written request for the review criteria used by Wellpoint in giving its first

adverse decision, the finding shall include copies of any additional clinical review criteria used in arriving at the decision;

· The notice will advise you of further external review/complaint rights provided to You:

o That the Member, the Member's authorized representative, or the health care provider has a right to file a complaint with the Commissioner within 4 months after receipt of Our grievance decision;

o That a complaint may be filed without first filing a grievance if the Member, the Member's authorized representative, or the health care provider can demonstrate compelling reason to do so;

o The Commissioner's address, telephone number, and facsimile number;

o A notification that when filing a complaint with the Commissioner, the Member, Member's authorized representative, or the Health Care Provider will be required to authorize the release of any medical records of the member that may be required to be reviewed for the purpose of reaching a decision on the complaint;

o A statement that the Health Advocacy Unit is available to assist the Member or the Member's authorized representative in filing a complaint with the Commissioner; and,

o The address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit.

Notification of a Coverage Decision

In the case of a Coverage Decision, We will provide the Member, Member's Representative and the treating Health Care Provider, a written Notice of the Coverage Decision within 30 calendar days. The statement will state in detail, clear and understandable language, the specific factual basis for Our decision and will include the following information:

· Where applicable, the identity of the claim involved (including the date of service, the Health Care Provider and the claim amount);

· The specific reason or reasons for the Coverage Decision;

· Reference to the specific Plan provisions on which the Coverage Decision is based;

· A description of any additional material or information necessary for the Member, the Member's Representative or Health Care Provider acting on behalf of the Member to perfect the claim and an explanation of why such material or information is necessary;

· A description of Our review procedures and the time limits applicable to such procedures, including a statement of the Member's right to bring a civil action under Section 502(a) of the Act following a Coverage Decision;

· That the Member, Member's Representative or Health Care Provider acting on behalf of the Member has a right to file an Appeal with us;

· In the case of a Coverage Decision by Us concerning an Urgent medical condition, a description of the expedited review process applicable to such claims. This information may be provided orally to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. The Member, the Member's Representative or Health Care Provider acting on behalf of the

Member must be provided a written or electronic Notification no later than one (1) day after the oral Notification;

· That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within 4 months after receipt of the Our Appeal Decision;

· That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member may file a Complaint with the Commissioner without first filing an Appeal, if the Coverage Decision involves an Urgent medical condition which has not been rendered;

· The Commissioner's address, telephone number, and facsimile number;

· A statement that the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in both mediating and filing an Appeal; and

· The Health Advocacy Unit's address, telephone number, facsimile number, and electronic mail address.

Complaint Process

We are available to provide reasonable, informative responses to problems or concerns that you may have about us, regarding issues such as our quality of service provided to you, or related to benefit determinations, coverage terminations or the quality of care or service rendered by providers in our network. Please contact the Member Services Department at the phone number listed on your identification card.

You, your authorized representative, or a health care provider on your behalf may file a complaint with the Maryland Insurance Administration, without having to first file an appeal/grievance with Wellpoint if:

· We waive the requirement to exhaust Our internal Appeal process.

· We fail to comply with any of the requirements of Our internal Appeal process; or

· We have denied authorization for a healthcare service not yet provided to You; and

· You, Your authorized representative, or Provider can show a compelling reason to file a complaint, A compelling reason includes showing that the potential delay in receipt of a health care service until after the member or health care provider exhausts the internal grievance process and obtains a final decision under the grievance process could result in:

1) Loss of life;

2) Serious impairment to a bodily function;

3) Serious dysfunction of a bodily organ;

4) The member remaining seriously mentally ill or using intoxicating substances with symptoms that cause the member to be in danger to self or others; or

5) The member continuing to experience severe withdrawal symptoms. A member is considered to be in danger to self or others if the member is unable to function in activities of daily living or care for self without imminent dangerous consequences.

· You, your authorized representative, or provider acting on your behalf may file a complaint if you

do not receive a grievance decision from us within 30 working days of filing the grievance. Note: In a case involving a retrospective denial, there is no compelling reason to allow a member, a member's representative, or a health care provider on behalf of a member to file a complaint without first exhausting the internal grievance process of a carrier.

When filing a complaint with the Commissioner, You or Your authorized representative will be required to authorize the release of any medical records that may be required to be reviewed for the purposes of reaching a decision on the complaint.

The Commissioner's address, telephone number, and facsimile number is:

Maryland Insurance Administration Appeal and Grievance Unit
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
Phone: 410-468-2000 or 1-800-492-6116 TTY Phone: 1-800-735-2258
Fax: 410-468-227073

The Health Advocacy Unit is available to assist the member or the member's representative in both mediating and filing an appeal or grievance under the carrier's internal grievance process.
For assistance with filing a complaint with the Commissioner; you, your authorized representative, practitioner, or health care provider may contact the Health Advocacy Unit of Maryland's Consumer Protection Division at:

Office of the Attorney General Consumer Protection Division Health Education and Advocacy Unit (HEAU)
200 Saint Paul Place, 16th Floor
Baltimore, Maryland 21202-2021
Phone: 410-528-1840 Toll Free: 1-877-261-8807 TTY Phone: 1-800-576-6372 Fax: 410-576-6571
E-mail: heau@oag.state.md.us

Grievances and Appeals Process
You or Your authorized representative, if not satisfied with the initial adverse decision or coverage decision, may submit a grievance or an appeal to the Wellpoint Grievance and Appeals Department. A request for an appeal or grievance may be done orally or in writing written request must state plainly the reason(s) why the Member disagrees with Our claim decision, Our refusal to authorize or cover a requested service or supply, or how We calculated the benefit. The request should include any pertinent documents and medical records not originally submitted with the claim or request for the service or supply and any other information that the Member feels may have a bearing on the decision. Also, please include the following details with Your request if You have them:

· The Member's name, address and phone number;
· The identification number as shown on Your Identification Card (including the three letter prefix);
· The name of the Provider who will or has provided care;
· The date(s) of service;

· The claim or reference number for the specific decision with which You do not agree; and
· Any bills that You have received from the Provider.

Adverse Decision - Grievance Process
A Grievance must be filed within 180 calendar days after the member receives an adverse decision. Upon receipt of a grievance, the following steps and actions take place:

· We fully investigate and document the content of a grievance and document Our findings. Investigation and documentation includes, but not limited to:
  - o The Member's reason for filing the grievance of the adverse decision;
  - o Additional clinical or other information provided with the grievance request;
  - o Previous adverse decision or grievance history;
  - o Follow-up activities associated with the adverse decision and conducted before the current grievance.

· We will review the information submitted to determine if it is sufficient to process the grievance. If it is not sufficient, within five working days after receipt of the grievance, we will notify you, your representative, or the health care provider that we can not proceed with reviewing the grievance unless additional information is provided; request the specific information, including any lab or diagnostic test or other medical information that must be submitted to complete the internal grievance process; and provide the specific reference, language, or requirements from the criteria and standards we use to support the need for the additional information; and we will assist the member or health care provider in gathering the necessary information without further delay.

· We will review the grievance and make a determination. If sufficient information is available, a health professional may review the grievance and overturn the initial review adverse decision if clinical criteria are fulfilled.

· If the initial review adverse decision cannot be overturned by the health professional, the grievance will be forwarded to the grievance reviewer for a determination. Grievances will be reviewed by an appropriate peer or peers who have not been involved with a prior finding.

· If the grievance is not reviewed by a health professional, the grievance will be forwarded to the grievance reviewer for a determination.

The final decision will be made in writing within 30 working days after the date the grievance is filed. For grievances that involve a retrospective denial, the final decision will be made in writing within 45 working days after the grievance is filed. We may extend the 30 day or 45-day period required for making the final decision with the written consent of you, your authorized representative, or your health care provider who filed the grievance on your behalf. The extension will not exceed 30 working days.

For nonemergency cases, when a grievance decision is rendered, We will inform the Member, the

Member's representative, or the health care provider acting on behalf of the member of the grievance decision: by oral communication and we will send, within 5 working days after the grievance decision has been made, a written notice to the Member, Member's representative, and a Health Care Provider acting on behalf of the Member.

The grievance notice will include:

· The name, address, telephone number of the Medical director or associate Medical Director, as appropriate, who made the grievance decision.
· The direct telephone number for the Wellpoint Grievances and Appeals department.
· A statement in clear, understandable language the specific factual basis for our decision and the reasoning used to determine that the health care service is not medically necessary and did not meet our criteria and standards used in conducting the utilization review.
· The reviewers' finding in clear terms and the reason in enough detail for the Member to respond to Our finding.
· The specific reference, language, or requirements from the criteria and standards, including any interpretive guidelines, on which the decision was based, and may not solely use: generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure, or "not medically necessary".
· The finding shall include instructions for requesting copies of any referenced evidence, documents or clinical review information not already provided to the Member. Where a Member had already sent in a written request for the review criteria used by Wellpoint in giving its first adverse decision, the finding shall include copies of any additional clinical review criteria used in arriving at the decision.
· The notice will advise You of procedures and further external review/complaint rights provided to you:

o That the Member, the Member's authorized representative, or the health care provider has a right to file a complaint with the Commissioner within 4 months after receipt of Our grievance decision;
o The Commissioner's address, telephone number, and facsimile number;
o A notification that when filing a complaint with the Commissioner, the Member, Member's authorized representative, or the Health Care Provider will be required to authorize the release of any medical records of the member that may be required to be reviewed for the purpose of reaching a decision on the complaint;
o A statement that the Health Advocacy Unit is available to assist the Member or the Member's authorized representative in filing a complaint with the Commissioner; and,
o The address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit.

Emergency Case Grievances

We will initiate the expedited procedure for an emergency case if the Member or the Member's authorized representative requests the expedited review or the health care provider or the member or the member's representative attests that:

1. The adverse decision was rendered for health care services that are proposed by have not been provided; and
2. The services are necessary to treat a condition or illness that, without immediate medical attention, would:
    a) Seriously jeopardize the life or health of the member or the member's ability to regain maximum functions;
    b) Cause the member to be in danger to self or others; or
    c) Case the member to continue using intoxicating substances in an imminently dangerous manner.

You can mail Your request, but it is best if you call the Grievances and Appeals department directly at 833-824-2561 or fax Your request to 855-298-4264 for medical or pharmacy or 877-487-7394 for behavioral health so We can handle it quickly.

For grievances concerning emergency cases, we will make a determination and provide verbal notification within 24 hours of the request, and written notice of the decision will be sent to the member, the member's representative and the health care provider within one day after the oral decision has been communicated. Verbal notification does not replace electronic or written notification of emergency grievance decisions, but when verbal notification is provided: Verbal notification requires communication with a live person; the organization may not leave a voicemail. We record the time and date of the notification and the staff member who spoke with practitioner or healthcare Provider, the Member or the Member's authorized representative.

Coverage Decision - Appeal Process
If You, your authorized representative or health care provider, is not satisfied with the initial coverage decision, may submit an appeal to the Wellpoint Grievances and Appeals Department. As noted above, coverage decisions include nonpayment of all or any part of a claim and does not include an adverse decision involving a medical necessity review or pharmacy inquiry.

You, your authorized representative or a health care provider filing a complaint on behalf you may file a complaint with the Commissioner without first filing an appeal with us only if the coverage decision involves an urgent medical condition, for which care has not been rendered.

We will render the appeal decision in writing to you, your authorized representative or health care provider acting on your behalf within 60 working days after the date on which the appeal is filed. Within 30 calendar days after the appeal decision has been made, we shall send you, your authorized representative, and the health care provider acting on your behalf a written notice of the appeal decision.

The notice of the appeal decision will state in detail in clear, understandable language, the specific factual bases for our decision. The notice will advise you of further external review/complaint rights provided to you:

· That the Member, the Member's authorized representative, or the health care provider has a right to file a complaint with the Commissioner within 4 months after receipt of Our appeal decision;
· The Commissioner's address, telephone number, and facsimile number;
· A statement that the Health Advocacy Unit is available to assist the Member or the Member's authorized representative in filing a complaint with the Commissioner; and,
· The address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit.

External Complaint
You, Your authorized representative (Your doctor, friend, spouse, neighbor, attorney, etc.) may have more rights available under Maryland law. You or Your authorized representative has a right to file a complaint with the Insurance Commissioner within 4 months after receipt of a grievance or an appeal decision. There is no filing fee. To file a complaint with the Commissioner, Your or Your authorized representative must contact:

Maryland Insurance Administration
Appeal and Grievance Unit
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
Phone: 410-468-2000 or 800-492-6116
TTY Phone: 800-735-2258
FAX: 410-468-2270
Email: agcomplaints.mia@maryland.gov

The Health Advocacy Unit is available to assist the member in both mediating and filing a grievance or an appeal under the carrier's internal grievance process. The Health Advocacy Unit contact information is:

Office of the Attorney General Consumer Protection Division
Health Education and Advocacy Unit (HEAU)
200 Saint Paul Place
Baltimore, Maryland 21202-2021
Phone: 410-528-1840
Toll Free: 877-261-8807
TTY: 800-576-6372
Fax: 410-576-6571
Email: heau@oag.state.md.us

Authorized Representative
You can choose someone to act for You or help You during the Complaint, Grievance, or Appeal process. We call this a "Member's authorized representative". They can be anyone – Your doctor, friend, relative, spouse, neighbor, attorney, etc. You must let Us know in writing if You want to choose a Member authorized representative. Send a letter to:

Wellpoint, Inc
Attention: Grievances and Appeals
P.O. Box 105568,
Atlanta, GA 30348-5568

Please include the following details:

· Your name, ID number, date of birth and full address.
· The full name of the person You have chosen to act for You.
· That You are giving Us permission to share protected health information (PHI) with this person.
· The purpose for disclosing PHI to this person.
· A description of the specific information We can share.
· The date Your authorization expires.
· That You understand that You have the right to withdraw Your authorization at any time in writing.
· That You understand We are not responsible if Your Member authorized representative shares Your PHI with others.
· That You understand You are not required to provide authorization to receive treatment, payment, for enrollment or to be eligible for benefits.
· You must also sign and date the letter.

Medical and Prescription Drug Appeals
Please submit Appeals regarding Medical and Prescription Drug coverage to the following address:
Wellpoint, Inc
Attention: Grievance and Appeals
P.O. Box 105568
Atlanta, GA 30348-5568

Dental Coverage Appeals
Please submit Appeals regarding Your dental coverage to the following address:
Wellpoint,Inc.
P.O. Box 1122
Minneapolis, MN 55440-1122

Wellpoint Vision Coverage Appeals
Please submit Appeals regarding Your vision coverage to the following address:
Wellpoint Vision
P.O. Box 9304
Minneapolis, MN 55440-9304