WEST VIRGINIA CODE: §33-25A-12

§33-25A-12. Grievance procedure.

(a) A health maintenance organization shall establish and maintain a grievance procedure, which has been approved by the Commissioner, to provide adequate and reasonable procedures for the expeditious resolution of written grievances initiated by enrollees concerning any matter relating to any provisions of the organization's health maintenance contracts, including, but not limited to, claims regarding the scope of coverage for health care services; denials, cancellations or nonrenewals of enrollee coverage; observance of an enrollee's rights as a patient; and the quality of the health care services rendered.

(b) A detailed description of the HMO's subscriber grievance procedure shall be included in all group and individual contracts as well as any certificate or member handbook provided to subscribers. This procedure shall be administered at no cost to the subscriber. An HMO subscriber grievance procedure shall include the following:

(1) Both informal and formal steps shall be available to resolve the grievance. A grievance is not considered formal until a written grievance is executed by the subscriber or completed on forms prescribed and received by the HMO;

(2) Each HMO shall designate at least one grievance coordinator who is responsible for the implementation of the HMO's grievance procedure;

(3) Phone numbers shall be specified by the HMO for the subscriber to call to present an informal grievance or to contact the grievance coordinator. Each phone number shall be toll free within the subscriber's geographic area and provide reasonable access to the HMO without undue delays. There must be an adequate number of phone lines to handle incoming grievances;

(4) An address shall be included for written grievances;

(5) Each level of the grievance procedure shall have some person with problem-solving authority to participate in each step of the grievance procedure;

(6) The HMO shall process the formal written subscriber grievance through all phases of the grievance procedure in a reasonable length of time not to exceed sixty days, unless the subscriber and HMO mutually agree to extend the time frame. If the complaint involves the collection of information outside the service area, the HMO has thirty additional days to process the subscriber complaint through all phases of the grievance procedure. The time limitations prescribed in this subdivision requiring completion of the grievance process within sixty days shall be tolled after the HMO has notified the subscriber, in writing, that additional information is required in order to properly complete review of the grievance. Upon receipt by the HMO of the additional information requested, the time for completion of

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the grievance process set forth in this subdivision shall resume;

(7) The subscriber grievance procedure shall state that the subscriber has the right to appeal to the Commissioner. There shall be the additional requirement that subscribers under a group contract between the HMO and a department or division of the state shall first appeal to the state agency responsible for administering the relevant program, and if either of the two parties are not satisfied with the outcome of the appeal, they may then appeal to the Commissioner. The HMO shall provide to the subscriber written notice of the right to appeal upon completion of the full grievance procedure and supply the Commissioner with a copy of the final decision letter;

(8) The HMO shall have physician involvement in reviewing medically related grievances. Physician involvement in the grievance process should not be limited to the subscriber's primary care physician, but may include at least one other physician;

(9) The HMO shall offer to meet with the subscriber during the formal grievance process. The location of the meeting shall be at the administrative offices of the HMO within the service area or at a location within the service area which is convenient to the subscriber;

(10) The HMO may not establish time limits of less than one year from the date of occurrence for the subscriber to file a formal grievance;

(11) Each HMO shall maintain an accurate record of each formal grievance. Each record shall include the following: A complete description of the grievance, the subscriber's name and address, the provider's name and address and the HMO's name and address; a complete description of the HMO's factual findings and conclusions after completion of the full formal grievance procedure; a complete description of the HMO's conclusions pertaining to the grievance as well as the HMO's final disposition of the grievance; and a statement as to which levels of the grievance procedure the grievance has been processed and how many more levels of the grievance procedure are remaining before the grievance has been processed through the HMO's entire grievance procedure.

(c) Copies of the grievances and the responses to the grievances shall be available to the Commissioner and, subject to state and federal privacy laws, to the public for inspection for five years.

(d) Any subscriber grievance in which time is of the essence shall be handled on an expedited basis, such that a reasonable person would believe that a prevailing subscriber would be able to realize the full benefit of a decision in his or her favor.

(e) Each health maintenance organization shall submit to the Commissioner an annual report in a form prescribed by the Commissioner which describes the grievance procedure and contains a compilation and analysis of the grievances filed, their disposition, and their underlying causes.

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