WEST VIRGINIA CODE: §33-25D-14

§33-25D-14. Grievance procedure.

(a) A prepaid limited health service 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 limited health service 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 prepaid limited health service organization'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. A prepaid limited health service organization 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 prepaid limited health service organization;

(2) Each prepaid limited health service organization shall designate at least one grievance coordinator who is responsible for the implementation of the prepaid limited health service organization's grievance procedure;

(3) Phone numbers shall be specified by the prepaid limited health service organization 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 prepaid limited health service organization without undue delays. There shall 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 prepaid limited health service organization shall process the formal written subscriber grievance through all phases of the grievance procedure in a reasonable length of time not to exceed forty-five days, unless the subscriber and prepaid limited health service organization mutually agree to extend the time frame. If the complaint involves the collection of information outside the service area, the prepaid limited health service

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organization 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 are tolled after the prepaid limited health service organization has notified the subscriber, in writing, that additional information is required in order to properly complete review of the grievance. Upon receipt by the prepaid limited health service organization of the additional information requested, the time for completion of the grievance process set forth in this subdivision resumes;

(7) The subscriber grievance procedure shall state that the subscriber has the right to appeal to the commissioner within thirty days of receipt by the subscriber of a written ruling by the prepaid limited health service organization which denies, in whole or in part, relief requested by the subscriber in a formal written subscriber grievance. There shall be the additional requirement that subscribers under a group contract between the prepaid limited health service organization and a department or division of the state shall first appeal to the state agency responsible for administering the relevant program, and if either party is not satisfied with the outcome of the appeal, the unsatisfied party may appeal to the commissioner. The prepaid limited health service organization shall provide the subscriber a 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. A subscriber has thirty days after receipt of the written notice to appeal to the commissioner if the prepaid limited health service organization's ruling denies the relief requested by the subscriber, in whole or in part;

(8) The prepaid limited health service organization shall have provider involvement in reviewing grievances related to a provider's services. Provider involvement in the grievance process may not be limited to the subscriber's coordinating provider, but shall include at least one other provider;

(9) The prepaid limited health service organization 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 prepaid limited health service organization within the service area or at a location within the service area which is convenient to the subscriber;

(10) The prepaid limited health service organization may not establish time limits of less than one year from the date of occurrence for the subscriber to file a formal grievance. The date of occurrence is the date upon which a claim, service or other matter sought by the subscriber was denied by the prepaid limited health service organization or date of occurrence of the event which gave rise to the grievance;

(11) Each prepaid limited health service organization shall maintain an accurate record of each formal grievance. Each record shall include the following:

(A) A complete description of the grievance, the subscriber's name and address, the provider's name and address and the prepaid limited health service organization's name and address;

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(B) A complete description of the prepaid limited health service organization's factual findings and conclusions after completion of the full formal grievance procedure;

(C) A complete description of the prepaid limited health service organization's conclusions pertaining to the grievance as well as the prepaid limited health service organization's final disposition of the grievance; and

(D) 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 prepaid limited health service organization's entire grievance procedure.

(12) Copies of the grievances and the responses thereto shall be available to the commissioner and the public for inspection for three years.

(c) Any subscriber grievance in which time is of the essence shall be handled on an expedited basis, so 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.

(d) Each prepaid limited health service 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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