

INSURANCE COMPLAINT

Administrative Review of Health Insurance Benefit Complaints and Appeals

If you filed a grievance with your health plan and are dissatisfied with the plan's final decision, you can request an administrative review from the Department of Employee Trust Funds (ETF). To request a review, you must contact ETF within sixty days of the date of the plan's final decision. **You must exhaust all levels of appeal through the plan before requesting an ETF administrative review.**

ETF offers you three levels of administrative review:

- 1. File a Complaint with the Quality Assurance Services Bureau (QASB).** An informal review, this level allows the most latitude for resolution of your problem. Examples of disputes reviewed at this level include plan denials of benefits and plan denials of referrals. The Quality Assurance staff act as "ombudspersons" for participants in the Department's programs. Acting as a neutral third party, the ombudspersons advocate for participants and attempt to resolve complaints and disputes on their behalf.
- 2. File a Request for Departmental Determination.** ETF has the authority to issue determinations based on the language of the contract, or applicable Wisconsin statute or Wisconsin Administrative Code. This is a more formal process than the review by the ombudsperson. You may choose to begin with the ombudsperson level or request a departmental determination as your first level of administrative review.
- 3. Appeal to the Group Insurance Board via Administrative Hearing.** This is the final level of administrative review. You must receive a departmental determination before you can file an appeal. The appeal process involves a pre-hearing conference to determine the issue(s) in dispute, followed by a formal hearing by a hearing examiner. The hearing examiner then makes a recommendation to the Group Insurance Board, which the Board may or may not accept. You may choose to retain an attorney for this or any other level of appeal.

The following provides additional information on each level of administrative review.

Written Complaint to ETF - Quality Assurance Services Bureau Review

Complaints must be in writing via this *Insurance Complaint* form. In addition to a brief description of the issue, please include copies of letters between you and the plan or provider, bills, dates of service and the total dollar amount of any denied claims. Upon receipt, an ombudsperson will acknowledge your written complaint and indicate when the review is expected to begin. If necessary, the ombudsperson will request additional information.

Once the review is completed, the results will be sent to you in writing. If a satisfactory resolution is not reached, you have the right to request a departmental determination as described below. While many disputed are resolved at this level, you may choose to waive the ombudsperson review and proceed directly to the departmental determination level. For example, if your dispute is with the plan's interpretation of a contractual provision, an ombudsperson has limited ability to resolve the dispute.

Written Request for Departmental Determination

You must submit a written request to ETF for a departmental determination within **60 days** from the date of the ombudsperson's final letter to you or the completion of the plan's grievance appeal process.

The review at this level is to establish whether the plan acted in accordance with the contract. In your request for departmental determination, you should note the areas of the contract or Uniform Benefits where you believe the plan is in violation. The departmental determination will be provided to you in writing.

If the departmental determination upholds the plan's final decision, you may appeal to the Group Insurance Board. Appeals to the Group Insurance Board must be filed within **90 days** of the date of the written determination.

Written Appeal to the Group Insurance Board – Administrative Hearing

This is the final administrative review level available to you through ETF. All appeals are conducted in accordance with ETF Chapter 11, Wisconsin Administrative Code. You must first receive a departmental determination in order to appeal to the Group Insurance Board. The Group Insurance Board only has authority to hear appeals relating to issues that arise under the terms and conditions of Uniform Benefits or other applicable contract.

Your appeal to the Board must be in writing and identify the specific facts or legal interpretations that you believe are in error. Include your name, address, and telephone in your appeal letter. **The Appeals Coordinator must receive the written appeal within 90 days of the date of the departmental determination. Appeals should be sent to the Appeals Coordinator, at the address shown below.**

A hearing examiner presides over the appeal process. The appeal process consists of several parts, including the pre-hearing conference, the hearing, and an issuance of a proposed decision. The Board then considers all of the evidence and issues a final decision. This process may take up to a year to complete, depending on the backlog of pending cases.

Parties who disagree with the final decision may appeal to the Dane County Circuit Court for certiorari review within 30 days of the notice of final decision.

To learn more about the appeal process, please request an *Administrative Appeals Process* brochure (ET-4943).

To request an administrative review:

Please indicate the level of review requested (i.e., ombudsperson or departmental determination) and send this completed, signed form to:

Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931

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P.O. Box 7931
Madison, WI 53707-7931**

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TO FILE A COMPLAINT: Your first step to resolve a problem is to contact the insurance carrier and try to resolve the problem at that level. If you are dissatisfied with the outcome, then complete this form and send it to the Department of Employee Trust Funds (ETF) at the address shown above, attention Quality Assurance Services Bureau.

Subscriber Name (First, MI, Last)		Birthdate	
Social Security Number		Daytime Telephone	()
Subscriber Address			
E-mail Address (optional)			

PLEASE ATTACH A DESCRIPTION OF YOUR PROBLEM. Include copies of important papers and letters that pertain to your complaint, including any authorizations or letters from the plan.

COMPLAINT INFORMATION:

1. Who is the covered individual that this complaint involves?
 - Self Other _____
(name/age/relationship)
2. Indicate the type of insurance complaint:
 - Health

Name of Health Plan or Pharmacy Benefit Manager
 - Pharmacy Benefit Manager
 - Income Continuation/Disability
 - Other _____
3. This complaint should **FIRST** have been reported to the plan. Have you completed their complaint resolution/grievance process? Yes No
4. Have you reported this problem to us or any other government agency, such as Office of Commissioner of Insurance?
 - Yes No If yes, what agency and what action was taken? (attach documentation, if available)

AUTHORIZATION FOR RELEASE OF INFORMATION:

I authorize _____ (name of health plan and/or provider) to release my medical and claims information to the ETF Quality Assurance Services Bureau for the purpose of addressing my insurance complaint.

Dates covered by this Authorization	From:	To:
Health Information to be Released Under this Authorization	PARTICIPANT'S GRIEVANCE FILE AND ANY RELATED HEALTH INFORMATION. Additional Information to be released (please describe):	

By signing this form, I acknowledge that I have read and understand my rights as listed on the reverse side.

Date (MM/DD/CCYY)	Signature:
<input type="checkbox"/> Self <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Personal Representative, Executor or Conservator <input type="checkbox"/> Other _____ <input type="checkbox"/> Power of Attorney for Health Care (activated)	

EXPIRATION: This authorization expires one year from the date signed, or upon withdrawal or resolution of complaint.

PURPOSE

I understand this authorization is for the purpose of giving the specified individually identifiable health information to ETF so that ETF may take steps to resolve my insurance complaint.

EFFECT OF REFUSAL TO SIGN AUTHORIZATION

This authorization is voluntary. I understand I may refuse to sign this authorization. However, failure to provide a signed authorization may effectively prohibit ETF from addressing my complaint.

REDISCLASURE

Federal privacy laws require I be informed that information used or disclosed pursuant to an authorization may be subject to redisclosure by the recipient and no longer be protected by federal privacy regulations.

TREATMENT, PAYMENT, ENROLLMENT, AND ELIGIBILITY FOR BENEFITS

Any organization or person described above who I am authorizing to use or disclose my health information is not permitted to condition treatment, payment, enrollment in a health plan, or eligibility for health benefits on my refusal to sign this authorization.

RIGHT TO REVOKE

I understand I may revoke this authorization at any time by notifying, IN WRITING, the ETF Quality Assurance Services Bureau. I understand that if I do revoke this authorization, such revocation does not affect any uses or disclosures before the written revocation is received.

RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION

I understand that I have a right to receive a copy of this completed form, upon request.