

THE DISTRICT OF COLUMBIA  
DEPARTMENT OF HEALTH  
ANNUAL  
HEALTH BENEFITS PLAN MEMBERS BILL OF  
RIGHTS REPORT

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ANNUAL HEALTH BENEFITS PLAN  
MEMBERS BILL OF RIGHTS REPORT

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## **I. HEALTH BENEFIT PLAN MEMBERS BILL OF RIGHTS**

The Health Benefit Plan Members Bill of Rights passed by the Council of the District of Columbia in 1998 (as codified at D.C. Official Code § 44-301 *et seq.*), established a procedure for members to appeal adverse decisions made by insurers, that deny, limit, or terminate covered medical services on the grounds of an absence of medically necessary.

The law requires that:

- (1) health insurers to send a written notice informing the member or the member's representative of the adverse decision within five (5) business days of the denial;
- (2) the written notice contain an explanation of the internal and external grievance processes available; and
- (3) in the event of an appeal, as a result of an adverse decision letter from the insurer, the member must file an external appeal to the Director of the Department of Health (DOH) or his designee, and the DOH Grievance and Appeals Unit, within thirty (30) business days after receipt of an adverse decision letter from the insurer.

Additionally, the law requires:

- (1) DOH to contract with the Independent Review Organization (IRO) to review appeals;
- (2) all insurers to report their number of adverse decisions to DOH; and
- (3) health insurers to compile and submit an annual report summarizing the data reported on adverse decisions to DOH.

## **II. DISTRICT OF COLUMBIA'S GRIEVANCE AND APPEALS LAW**

The review of adverse decisions is divided into two parts: a) internal review, which is conducted by the insurer; and b) external review, which is conducted by DOH.

### **A. Internal Review: Insurer's Internal Grievance Process**

If an insurer denies services based upon the absence of medical necessity, the insurer must provide its members with a written adverse decision within five (5) business days. The written adverse decision must include the following:

- A clearly stated decision;
- A detailed, comprehensive, contractual or medical rationale explaining the insurer's decision;
- An explanation of the insurer's internal grievance process;

- Notice that DOH has the authority to facilitate an external appeals process if members are dissatisfied with the insurer's grievance decision;
- Notice that members have thirty (30) business days from the date of the final adverse decision to file an appeal with DOH; and
- The address, telephone number, and facsimile number of the DOH designee.

### **1. Requirements of Insurers**

D.C. Official Code § 44-301.10 *et seq.* requires insurers to submit an annual report, which chronicles all activity during the preceding year. The report must include the following:

- The name and location of the reporting insurer;
- The reporting period in question;
- The name of the individual responsible for the operation of the insurer's grievance system;
- The total number of grievances received by the health insurer categorized by cause, insurance status, and disposition;
- The total number of grievances for expedited review categorized by cause, resolution time-line, and disposition; and
- The total number of appeals for external review categorized by cause, resolution time-line, and disposition.

### **B. External Review: DOH Appeals Process**

If members are dissatisfied with the insurer's decision related to the determination of a claim of medical necessity, members may file an appeal at the following address: ***District of Columbia Department of Health, Medical Assistance Administration, Attn: Grievance and Appeals Unit, 825 North Capitol Street, N.E., 4<sup>th</sup> Floor, Washington, D.C., 20002.***

The Grievance and Appeals Unit reviews cases to determine whether appeal cases should be referred to an Independent Review Organization (IRO) for medical review. IROs are separate entities under contract to DOH that review appeal cases. They are comprised of certified medical professionals and physicians who specialize in the issue under review. IROs assess appeal cases on the basis of medical records, practice guidelines, and applicable clinical protocols.

Additionally, independent reviews are conducted at no cost to the members. An IRO must render a decision within thirty(30) days after receiving relevant documents. In emergency cases, an IRO is required to render a decision within seventy-two (72) hours.

### **1. Additional Appeal Filing Locations**

If members have concerns regarding the quality of services rendered by a physician, they may file a complaint at the following address: ***District of Columbia Department of Health, Health Regulatory Administration, 825 North Capitol Street, N. E., 2<sup>nd</sup> Floor, Washington, D.C., 20002. The telephone number is (202) 442-5888.***

Also, if members have concerns about services covered in their insurer's contract, they may file a complaint at the following address: *Commissioner of the Department of Insurance, Securities and Banking, 810 First Street, N. E., 7<sup>th</sup> Floor, Washington, D.C., 20002. The telephone number is (202) 727-8000.*

### **III. CERTIFICATION OF INDEPENDENT REVIEW ORGANIZATIONS**

Upon certification of an IRO, the DOH Director imposes standards upon an independent review organization to ensure the following: (1) strict confidentiality when an appeal is reviewed; (2) the use of qualified professionals and medical reviewers; and (3) a demonstrated ability to render decisions in an equitable and timely manner.

An IRO may not be a subsidiary or in any way owned or controlled by a health insurer, or trade association of health care providers. The IRO should not have any material, professional, familial, or financial interests that could create the appearance of a conflict of interest with any of the following: (1) insurer; (2) officer, director, or management employee of the insurer; (3) physician, physician's medical group, independent practice associates, or the provider proposing the service or treatment; (4) institution where the service or treatment should be provided; or (5) the development or manufacture of the principal drug, device, procedure, or other therapy proposed for the member whose treatment is under review.

In situations where there is an appearance of impropriety, the Director of DOH has the discretion to deny an appeal assignment to a particular IRO. Lastly, neither the IRO nor an individual working for an external review panel can be held liable for any recommendation presented by the independent review organization, except in cases of gross negligence, recklessness, or intentional misconduct.

### **IV. STATISTICAL DATA BASED ON APPEALS FILED WITH DOH**

The Grievance and Appeals Unit determines where each appeal will be sent for review and resolution. During the reporting period October 1, 2006 through September 30, 2007, the DOH Grievance and Appeals Unit received a total of seventy-five (75) external appeals. Following is a breakdown of the results:

- **25** appeals (**33%**) involving coverage or contract interpretation were **Referred** to the Department of Insurance, Securities and Banking (DISB)
- **22** appeals (**29%**) asserting a denial of coverage based upon lack of medical necessity were **Reviewed** by IRO
- **11** appeals (**15%**) that did not involve medically necessary services, untimely filing, policy exclusion, or a provider filed untimely filing, policy exclusion, or an improper appeal filed on behalf of a member who was not responsible for the charges were **Rejected**.
- **5** appeals (**7%**) due to a lack of sufficient information were **Administratively Dismissed**, i.e. a letter requesting a member to sign the authorization for the release of

medical records or additional information needed was not received within a specified time frame.

- **5** appeals (**7%**) were **Referred** to another agency for resolution because of issues involving jurisdiction (the Grievance and Appeals Unit only has jurisdiction to review appeals regarding policies issued in the District of Columbia). Examples of those exempted are as follows: a) Department of Labor (ERISA)-self-insured employers; b) Office of Personnel Management (OPM)- federal government employees; and c) Maryland Insurance Administration (MIA)- policy issued in the State of Maryland.
- **5** appeals (**7%**) were **Held in Abeyance** and returned to the member to exhaust their internal appeals process with the insurer.
- **1** appeal (**1%**) was **Withdrawn** by the health insurer that reversed its decision prior to the external review.
- **1** appeal (**1%**) was **Pending** at the time this report was produced because of an outstanding request for medical records

## **V. CONSUMER AWARENESS**

The success of the program depends heavily on consumer awareness. The law requires all insurers issuing adverse decision letters to notify the member of the internal and external appeal processes. Despite all explanations, many consumers continuously express confusion and frustration about the internal grievance and external appeal processes. Consumers readily share their distrust in the decision-making process when receiving grievance and appeal decisions. While the negative perception remains, the health insurers' internal grievance process showed results that favor the consumer. (See Table E) In FY 2007, sixty-four percent (64%) of all denials of service were either overturned or the decision was modified.

In FY 2007, requests for assistance by consumers and providers were submitted through correspondence, telephone and facsimile inquiries. To ensure that members are aware of their appeal rights, DOH utilizes various consumer awareness efforts. DOH provides the following information:

- 1) an informational brochure outlining the grievance process; and
- 2) a web site that details information about the program, including an appeal form and an authorization for the release of medical records form.

## **VI. CONCLUSION**

Overall, in FY 2007, the Health Benefits Plan Members' Bill of Rights program was successful. The program processed one hundred percent (100%) of the appeals received and provided a greater degree of assistance to members than in previous years, while ensuring that each member received a full and fair review of their appeal.

Appeals accepted by DOH and referred to the IRO in 2007 can be separated into categories:

- 1) Inpatient Hospital Stay -1 appeal
- 2) Mental Health Services – 5 appeals
- 3) Physical Therapy -1 appeal
- 4) Orthopedic Services -1 appeal
- 5) Laboratory/Radiology Services -7 appeals
- 6) Dental Services -1 appeal
- 7) Pharmacy Services -2 appeals
- 8) Durable Medical Equipment -3 appeals
- 9) GYN/Maternity Services -1 appeal

Health insurers also reported the number of internal grievances which they overturned (See Tab B). The combined data shows that in 2007, thirty-six percent (36%) of the internal adverse decisions were upheld, and fifty-three percent (53%) were reversed with eleven percent (11%) resulting in modification.

Based on the reports submitted by the health insurers, it is clear that the law is having a positive effect on the consumers' ability to obtain medically necessary services. The Health Insurer's Annual Grievance Reports are set forth in the attached Appendix.

## **VII. RECOMMENDATIONS**

While the program is successful, there are measures that should be enacted to ensure that the health consumer's rights are fully protected. Therefore, in accordance with D.C. Official Code Sec. 44-301.10 (d), the following recommendations are made:

- (1) Determinations of the Independent Review Organizations should be binding on both parties or at a minimum the health benefit plan. Under current law the determinations are not binding. Therefore, if the health insurer decides not to abide by the determination of the independent review organization, the member would then have the expenses and time associated with seeking a remedy through the courts.
- (2) DOH should have regulatory authority under the law. DOH should have the authority to levy fines when a health insurer fails to follow the law, regulations or its internal grievance procedures.
- (3) The definition section of the law should be reviewed to ensure that it is consistent with current practice definitions. (Example: "Health Insurer", use HIPPA's definition to ensure no impact on self-insured plans under ERISA).



