

If you request it, the health plan must provide to you all material relevant to your grievance that is not confidential or privileged. You should also try to submit all information you want the Second Level Grievance Panel to review before and/or during the review meeting.

The Review Panel must issue a written decision to you within five working days of the Review meeting.

TIPS FOR SUCCESSFUL GRIEVANCES

A successful grievance will base its argument on logic and the policy's language. If you are not already familiar with your health insurance policy and your benefits, it's a good idea to do that. The policy will also describe the procedures you must follow in order to receive benefits.

If your position is rooted in an emotional basis, you would be wise to include a reason why it benefits the plan to agree with you. For example, if it will cost the plan more in the long run to deny services now, you will want to point that out to the plan.

Your medical provider can be your best ally in preparing your case. A supporting letter from the medical provider may be able to explain the medical rationale for your treatment, why treatment is necessary, or the history of your injury or illness. Also, make sure the plan receives a copy of all pertinent medical records, in case its original decision was based on incomplete information.

WHAT ELSE SHOULD I KNOW?

If you exhaust your plan's appeals process, you can still file a complaint with the Nebraska Department of Insurance.

The Department will review the plan's handling to look for any violations of state insurance laws, especially in regard to the grievance procedure requirements.

If your employer self-insures its health plan, state requirements for grievance procedures do not apply. Consult your health plan booklet or Summary Plan Description for a description of your grievance procedures.



State of Nebraska
Department of Insurance
941 'O' Street, Suite 400
Lincoln, Nebraska 68508-3639
Phone (402) 471-2201
Fax (402) 471-6559
TDD (800) 833-7352

www.doi.ne.gov

Your Grievance Rights in a Managed Care Plan



*Information from the
Nebraska Department of
Insurance*

If your individual or group health plan is a managed care product (a Preferred Provider Organization plan (PPO), Point of Service plan (POS), or Health Maintenance Organization (HMO)), and the application for that plan was signed in Nebraska, you are entitled to file a grievance with that plan pertaining to any problems you have with it.

A grievance is any written complaint you make about your health plan. Nebraska insurance laws specify the manner in which the company has to respond to your grievance. State law also stipulates the time frames within which the company must review your grievance and reply to you.

FIRST LEVEL GRIEVANCES

If you or your representative file a grievance, the health plan must either provide a written decision in regard to your grievance, or explain why it isn't possible to respond, within 15 working days after receiving your grievance. If the latter, the health plan has an additional 15 days to respond to your grievance. The people who review your grievance must be different than the employees who were originally involved in the decision that is the subject of your grievance.

You can provide additional written information to support your reasons for filing the grievance. In fact, successful grievances often provide information not originally reviewed by

the health plan. If you have no additional information to support your reasoning, you should at least submit a written reason why you think your grievance deserves merit.

The plan's written response to your grievance should include the following information:

- The names, titles and qualifying credentials of the grievance reviewers
- The reviewers' decision in clear terms
- The contract basis or medical rationale in enough detail for you to respond to their position
- A reference to the documentation the plan relied upon for its decision
- The written procedures for requesting a Second Level Grievance Review

EXPEDITED REVIEWS

If your health would be jeopardized by the waiting periods established for a First Level Grievance Review, you or your doctor can request an Expedited Review. You can do that in person, over the phone, or in writing. In obtaining information for the review, and in responding to you, the plan must use the fastest available method of receiving and transmitting information.

The health plan must provide you with a decision as quickly as your medical condition requires, but at least within 72 hours of starting its review.

If you are currently receiving services, and your grievance involves the continuation of this care, you can continue to receive that care while the plan is reviewing your grievance.

The plan has to provide you with a written follow-up to its oral decision within two days of providing you with that decision. If you still disagree with the plan, you can file a Second Level Grievance

SECOND LEVEL GRIEVANCES

If you still disagree with the plan's decision, you may request a Second Level Grievance Review. The plan must schedule and hold that Review within 45 working days of your request.

You have the right to appear in person before the people reviewing your grievance at this level. If your circumstances do not allow you to appear in person, you may still be able to "attend" the conference via some other means available to the plan, such as a conference call.

You can also have someone, such as your doctor, assist or represent you at the Review.