TITLE XXXVII
INSURANCE

CHAPTER 420-J
MANAGED CARE LAW

Section 420-J:5

420-J:5 Grievance Procedures. –

Every carrier or other licensed entity shall establish and shall maintain a written procedure by which a claimant or a representative of the claimant, shall have a reasonable opportunity to appeal a claim denial to the carrier or other licensed entity, and under which there shall be a full and fair review of the claim denial. The written procedure filed with the insurance department shall include all forms used to process an appeal.

I. Full and fair review shall require that:

(a) The persons reviewing the grievance shall not be the same person or persons making the initial determination, and shall not be subordinate to or the supervisor of the person making the initial determination;

(b) For medical necessity appeals at least one person reviewing the appeal is a practitioner in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment at issue in the appeal. A practitioner is considered of the same specialty if he or she has similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal. A practitioner is considered of a similar specialty if he or she has experience treating the same problems as those in question in the appeal, in addition to expertise treating similar complications of those problems;

(c) The claimant shall have at least 180 days following receipt of a notification of a claim denial to appeal;

(d) The claimant shall have an opportunity to submit written comments, documents, records, and other information relating to the claim without regard to whether those documents or materials were considered in making the initial determination;

(e) The claimant shall be provided upon request, and without charge, reasonable access to, and copies of all documents, records, and other information relevant to or considered in making the initial adverse claim determination; and

(f) The review shall be a de novo proceeding and shall consider all information, documents, or other material submitted in connection with the appeal without regard to whether the information was considered in making the denial.

II. In the appeal of a claim denial that is based in whole or in part on a medical judgment:

(a) The review shall be conducted by or in consultation with a health care professional in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment at issue in the appeal. A practitioner is considered of the same specialty if he or she has similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal. A practitioner is considered of a similar specialty if he or she has experience treating the same problems as those in question in the appeal, in addition to expertise treating similar complications of those problems;

(b) The titles and qualifying credentials of the person conducting the review shall be included in the decision; and

(c) The identity and qualifications of any medical or vocational expert whose advice was considered, without regard to whether it was relied upon in making the initial claim denial, shall be made available to the claimant upon request.

III. In the appeal of a claim for urgent care, a claim involving a matter that would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function, or a claim concerning an admission, availability of care, continued stay or health care service for a person who has received emergency services, but who has not been discharged from a facility, an expedited appeal process shall be made available which shall provide for:

(a) The submission of information by the claimant to the carrier by telephone, facsimile, or other expeditious method; and

(b) The determination of the appeal not more than 72 hours after the submission of the request for appeal.

IV. Timing and Notification for Determination on Appeal

(a) In the case of nonexpedited appeal of a pre-service claim or post-service claim, the determination on appeal shall be made within a reasonable time appropriate to the medical circumstances, but in no event more than 30 days after receipt by the carrier or other licensed entity of the claimant's appeal.

(b) In the case of an expedited appeal related to an urgent care claim, a carrier or other entity shall make a decision and notify the covered person as expeditiously as the covered person's medical condition requires, but in no event more than 72 hours after the appeal is filed. If the expedited review involves ongoing urgent care services, the service shall be continued without liability to the covered person until the covered person has been notified of the determination. A carrier or other licensed entity shall provide written confirmation of its decision concerning an expedited review within 2 business days of providing notification of that decision, if the initial notification was not in writing.

(c) The period of time within which a decision shall be rendered on appeal shall begin to run at the time the appeal is filed in accordance with the appeal procedures of the carrier or other licensed entity, without regard to whether all the information necessary to make a determination on appeal is contained in the filing. In the event the claimant fails to submit information necessary to decide the appeal, the period for making the determination on appeal shall be tolled from the date the claimant is notified in writing of precisely what is required until the date the claimant responds to the request. The carrier or other licensed entity shall provide notification of incompleteness as soon as possible; but in no event more than 24 hours after the filing of the appeal in appeals involving urgent care. In the event that the claimant fails, within a 45-day period from the date of notification, to provide sufficient information, the carrier may deny the appeal on the basis of incompleteness. The appeal may be reopened upon receipt of the required information.

V. Manner and Content of Notification of Determination on Appeal. The carrier or other licensed entity shall provide a claimant with a written determination of the appeal.

(a) Where a decision is made to uphold, in whole or in part, the denial of benefits, the written determination of appeal shall include:

(1) The specific reason or reasons for the determination, including reference to the specific provision, rule, protocol, or guideline on which the determination is based;

(2) A statement that the rule, protocol, or guideline governing the appeal will be provided without charge to the claimant upon request;

(3) A statement describing all other dispute resolution options available to the claimant, including, but not limited to other options for internal review and options for external review and options for bringing a legal action;

(4) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

(5) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the claim denial, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the claim denial and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(6) If the claim denial is based on a medical necessity or experimental treatment or similar exclusion or limit,

either an explanation of the scientific or clinical judgment for the denial, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
(7) If the appeal involves an adverse determination, a copy of the notice of the right to external review that includes the specific requirements for filing an external review; and
(8) A statement describing the claimant's right to contact the insurance commissioner's office for assistance which shall include the toll-free telephone number and address of the commissioner.
(b) A carrier or other licensed entity that offers group health plans, employee benefit plans, or disability plans shall file annually with the commissioner, as part of its annual report required by RSA 420-J:5, V(g), a certificate of compliance stating that the carrier or other licensed entity has established and maintained, for each of its health benefit plans, grievance procedures that fully comply with the provisions of this chapter. Material modifications to the procedure shall be filed with the commissioner prior to becoming effective.
(c) A carrier or other licensed entity that offers group health plans, employee benefit plans, or disability plans shall maintain written records documenting all grievances and appeals received during a calendar year, a general description of the reason for the appeal or grievance, the name of the claimant, the dates of the appeal or grievance and the date of resolution.
(d) A carrier or other licensed entity that offers group health plans, employee benefit plans, or disability plans shall provide to consumers:
(1) A description of the internal grievance procedure required under RSA 420-J:5 for claim denials and other matters and a description of the process for obtaining external review under RSA 420-J:5-a-RSA 420-J:5-e. These descriptions shall be set forth in or attached to the policy, certificate, membership booklet, or other evidence of coverage provided to covered persons.
(2) A statement of a covered person's right to contact the commissioner's office for assistance at any time. The statement shall include the toll-free telephone number and address of the commissioner.
(3) A statement that the carrier or other licensed entity will provide assistance in preparing an appeal of an adverse benefit determination, and a toll-free telephone number to contact the carrier or other licensed entity.
(e)(1) If a carrier or other licensed entity provides 2 mandatory levels of appeal, the first level shall be completed within 15 days and the second level completed within the 30-day time period beginning from the initial date of filing the appeal or grievance. If a carrier or other licensed entity provides a single mandatory level of appeal, the single mandatory level shall be completed within the 30-day time period beginning from the initial date of filing the appeal. With respect to a mandatory second level of appeal involving a claim for continuation of services or urgent care, the carrier or other licensed entity shall make a decision and notify the claimant within 72 hours after the mandatory second level appeal is filed. For appeals involving post-service claims, the carrier shall make a decision and notify the claimant within 60 days of the date the completed appeal was filed.
(2) Subparagraph (e)(1) shall not prohibit a carrier or other licensed carrier from offering additional voluntary levels of appeal in addition to any mandatory levels of appeal offered, provided that:
(A) The claimant may elect to pursue any additional level of appeal under this subparagraph voluntarily;
(B) A carrier may not assert failure to exhaust administrative remedies where a claimant elects to pursue a claim through other venues rather than through the voluntary level of appeal;
(C) Any statute of limitations or time limits to pursue other remedies shall be tolled during the voluntary appeals process;
(D) Voluntary levels of appeal are available only after a claimant has completed required mandatory levels of appeal required under the plan or by regulation;
(E) The carrier provides a claimant with sufficient information to make an informed decision whether to submit the claim through any voluntary appeals process;
(F) No fees or costs are imposed on the claimant as part of any voluntary appeals process; and
(G) Any voluntary level of appeal requested by a claimant under this subparagraph shall be completed within

30 days from the date of the request for the voluntary appeal.
(f) Annual reports shall be made to the insurance commissioner regarding plan complaints, adverse determinations, claim denials, and prior authorization statistics in such form and containing such information as the commissioner may prescribe by rule or otherwise.
(g) If the claimant has filed an appeal and the carrier or other licensed entity has not issued a decision within the required time frames, the carrier or other licensed entity shall promptly provide the claimant with a statement of the claimant's right to file an external appeal as provided in RSA 420-J:5-a-RSA 420-J:5-e. The statement of appeal rights shall include a description of the process for obtaining external review of a determination, a copy of the written procedures governing external review, including the required time frames for requesting external review, and notice of the conditions under which expedited external review is available.
VI. In an appeal of a claim denial or other matter, the claimant may authorize a representative to pursue a claim or an appeal by submitting a written statement to the carrier or other licensed entity that acknowledges the representation.
VII. No fees or costs shall be assessed against a claimant related to a request for a grievance or appeal.

Source. 1997, 345:1. 2000, 18:6-10, 17. 2001, 207:12. 2003, 175:9, 10. 2005, 248:9, 10, 20. 2007, 289:27, 28, eff. Jan. 1, 2008.