

Priority Health Insurance Company Grievance Process



Inquiry, grievance and expedited review procedure notification

We hope that you are always happy with the services you receive from Priority Health. If you have any questions or concerns, please call our Customer Service department. Our representatives will help you with your problem as quickly as possible.

Here's how to reach Customer Service:

Hours: 7:30 a.m. – 7:00 p.m. Monday through Thursday

9:00 a.m. – 5:00 p.m. Friday

8:30 a.m. – 12:00 p.m. Saturday

Phone: 888 389-6645

616 464-8830

Online: Send us a secure message through our website at priorityhealth.com.

If you are not happy with the answers that our representative has provided, you or someone acting on your behalf can send us a formal complaint. This formal complaint is called a grievance. You have two years from the date you learn of a problem to file a grievance with us. You can file a grievance to ask us to change a decision about any of the following:

- Benefits (including services determined to be experimental or investigational or not medically necessary or appropriate)
- Eligibility
- Payment of claims (in whole or in part)
- How we've handled payment or coordination of health care services
- Contracts with our providers
- Availability of care or providers
- Delivery or quality of health care services or
- A decision not in your favor. This may include services that have been reviewed by Priority Health and denied, reduced or terminated. It also may include a slow response to a request for a decision from us.

Grievance process

Step 1: Filing a grievance

How do I file a grievance with Priority Health?

Contact our Customer Service department to file a grievance with us. Our representatives will ask you to fill out a Grievance Form to tell us about your complaint. They can help you fill out this form. You can include extra information if you wish. **Note:** You are not required to use the Grievance Form to file a request for grievance. You may file a request by letter, fax, email or phone.

Who reviews a grievance?

The members of the Grievance Committee are Priority Health employees and include a medical doctor. Review by the Grievance Committee always includes an opinion from a doctor for health issues.

What happens after this review?

After we get your request and any information we need from health care providers or facilities, our Grievance Committee will meet to review your case. We will mail you a written response. If you are still not happy, you can ask for another review (see Step 2, Filing an Appeal).

How long will it take for me to get an answer?

If services have not been received:

Steps 1 and 2 combined must be completed with a final determination made within 30 calendar days after we receive your grievance and appeal forms. The 30 calendar days do not include any days you or your representative may delay the process. Neither the grievance step nor the appeal step may take more than 15 days, respectively.

If services have been received:

Steps 1 and 2 combined must be completed with a final determination made within 35 calendar days after we receive your grievance and appeal forms. The 35 calendar days do not include any days you or your representative may delay the process. Neither the grievance step nor the appeal step may take more than 30 days, respectively.

If we receive your grievance or appeal form during non-business hours, we count the time of receipt as the next business day.

Our Grievance Committee meets at least once a week. Our Appeal Committee meets every 14 days. Both committees may meet more often to meet these timeframes.

Step 2: Filing an appeal

If you do not like the decision from the Grievance Committee, you can ask for another review by completing an Appeal Form. You can include extra information if you wish. **Note:** You are not required to use the Grievance Form to file a request for grievance. You may file a request by letter, fax, email or phone.

Who reviews appeals?

The members of the Appeal Committee may include Priority Health employees, Priority Health members, local employers that offer Priority Health to their employees and physicians from the Priority Health network. Review by the Appeal Committee always includes an opinion from a doctor for health issues. The doctor is in the same or related specialty that may treat the health issue being reviewed.

What happens during this review?

After we receive your appeal, the Appeal Committee will then review your case. We will tell you the date, time and place where the review will be held. We will give you this information within five business days after we receive your request for appeal. We will explain what will happen during the review. You also can be at the review or have someone represent you at the review, or both. You will get a copy of the material that will be reviewed by the Appeal Committee free of charge. During the review you or your representative will have the chance to talk to the Appeal Committee.

What happens after this review?

The Appeal Committee will make a decision and we will mail you a written response within five full business days of the review. If you have gone through Steps 1 and 2 (above) and still are not happy with the decision, you may ask for a review by the State or take civil action.

How long will it take for me to get an answer?

If services have not been received:

Steps 1 and 2 combined must be completed with a final determination made within 30 calendar days after we receive your grievance and appeal forms. The 30 calendar days do not include any days you or your representative may delay the process. Neither the grievance step nor the appeal step may take more than 15 days, respectively.

If services have been received:

Steps 1 and 2 combined must be completed with a final determination made within 35 calendar days after we receive your grievance and appeal forms. The 35 calendar days do not include any days you or your representative may delay the process. Neither the grievance step nor the appeal step may take more than 30 days, respectively.

If we receive your grievance or appeal form during non-business hours, we count the time of receipt as the next business day.

Our Grievance Committee meets at least once a week. Our Appeal Committee meets every 14 days. Both committees may meet more often to meet these timeframes.

What can I do if I'm still not happy with the decision?

- You may bring a civil action under Sec. 502(a) of ERISA within three years after the date of service or after you learned coverage was denied; and/or
- You may ask for an external review through the Office of Financial and Insurance Regulation (OFIR).

Step 3: External review (State of Michigan)

If you ask for a review with OFIR, they will first determine:

- If your request is complete.
- If your request is accepted for external review.

If accepted for external review, your request will be assigned to an Independent Review Organization (IRO). You will not pay for any of the costs of the independent review.

How do I request an external review?

To request a review, you need to complete the form provided by Priority Health and contact the State. This form can also be found on the OFIR website listed below. This must be done no later than 60 days after you get a notice of a decision not in your favor from Priority Health. If Priority Health does not meet the timeline requirement for both Step 1 and 2 combined of the internal grievance process, you may also request a review by the State. If you have given Priority Health more time for a decision, you may not request a review until Priority Health has made its decision.

What information does OFIR need?

A Health Care-Request for External Review Form must be turned in to the State. This allows Priority Health and doctors to tell the State about your personal health information. You may also give other information about your case.

Here's how to contact the State:

Office of Financial and Insurance Regulation
Health Plans Division
611 West Ottawa, 3rd Floor
P.O. Box 30220
Lansing, MI 48909-7720

877 999-6442

michigan.gov/ofir

What does the State do when I send them a complaint?

The State tells Priority Health that they received your complaint. Within five business days, the State does a review to decide these things:

- If you or your dependent are or were covered under Priority Health.
- If the services seem to be a covered benefit.
- If you have gone through the Priority Health grievance process (unless it is not required).
- If you have given all the information you would like to be reviewed.
- If you have sent in the necessary form.

When this review is done, the State will tell you if your request is complete and if it has been accepted. If accepted, the State must:

- Tell you that you may send in additional information within seven business days.
- Tell Priority Health that your review request has been accepted.

If your review is not accepted, the State must tell you why. If it is not accepted due to incomplete information, the State must send you a letter to tell you what is missing.

What happens during the review process?

If your review request is accepted, an IRO is asked to perform the review and to make a recommendation to the State within 14 calendar days.

- The State gives the information you sent in to the IRO and to Priority Health.
- You and Priority Health will both receive letters telling the name of the IRO that will do the review. You have seven business days to send additional information to the IRO.
- Within seven business days after the letter, Priority Health must give the IRO any documents or information used to make the decision not in your favor. If Priority Health does not do this in seven business days, the State can reverse Priority Health's decision.
- Please note that complaints about medical issues are reviewed by an IRO. Complaints about non-medical contractual issues may be reviewed by the Commissioner of OFIR and/or an IRO.

What does the IRO look at during the review?

- Medical records related to the case
- The doctor or health care professional recommendations
- Opinions from similar health care professionals and other documents sent in
- Terms of benefit plan coverage
- Most appropriate practice guidelines
- Clinical review criteria developed by Priority Health that relates to your case

What happens after the review is done?

- The IRO must send a recommendation to the Commissioner of OFIR within 14 calendar days.
- The Commissioner reviews it to make sure it agrees with the terms of coverage.
- The Commissioner tells you and Priority Health of the decision within seven business days after getting the recommendation.
- If the Priority Health decision is reversed, we must approve coverage or pay claims right away.

Priority Health expedited review (emergency review)

Priority Health will follow a faster review process when there is an emergency.

How long does this process take?

We will make a decision within 72 hours (three days) from the time we get your request. This timeline begins when we receive your request. During non-business hours, you can leave a message at 877 954-1035 (toll free) to make a request.

When can I ask for an expedited review?

The faster process will be followed when you file a complaint (verbally or in writing) when the normal time to review your case (Steps 1 and 2 of the grievance process) would:

- put your life in danger
- interfere with your full recovery, or
- delay treatment for severe pain (must be confirmed by your doctor)

What happens after this review?

We will tell you by telephone right after we make the decision. We will also send a letter telling you about the decision within two business days after the decision. If you are not happy with the final decision, you may appeal to the State within 10 days after you receive the final decision about your expedited review.

State of Michigan expedited review (emergency external review)

The State will follow a faster review process when there is an emergency.

When can I ask for the State's expedited review?

An expedited review by the State may be asked for if:

- Your doctor tells the State by phone or in writing that Priority Health's review time would put your life in danger, or would interfere with your full recovery, and
- You have already asked for an expedited review by Priority Health.

How do I ask for the State's expedited review?

Priority Health will provide you with a Health Care-Request for External Review Form to start this process. You may also contact OFIR to get this form.

How long does this process take?

The State's expedited review will be done within 72 hours (three days) from the time the State gets it from you.

What information does OFIR need?

A Health Care-Request for External Review Form must be turned in to the State. This allows Priority Health and doctors to tell the State about your personal health information. You may also give other information about your case.

What happens during the State's expedited review?

Here's what happens at the State when you send in your request:

- The State tells Priority Health and decides if the request meets the requirements for an expedited external review.
- If accepted, your case is reviewed by an IRO, and they will determine if you need to complete a Priority Health expedited internal review first. If this occurs, it will be sent back to follow the Priority Health process.
- If accepted for an expedited external review, Priority Health must provide all paperwork and information to the IRO within 12 hours after we receive notice.
- The IRO must make a recommendation within 36 hours after getting the request.
- The Commissioner reviews the recommendation from the IRO. The Commissioner makes a final decision within 24 hours after receiving the recommendation.

What happens after this review?

If the Priority Health decision is reversed, we must approve coverage or pay claims right away.

Who decides which IRO reviews the complaints?

The Commissioner of OFIR must approve IROs. IROs cannot be owned or controlled by, be subsidiary of or in any way owned or controlled by or exercise control with the health plan; a national, state or local trade association of health benefit plans; or a national, state or local trade association of health care providers.