GOVERNMENT OF THE DISTRICT OF COLUMBIA

GRIEVANCES/APPEALS
(HEALTH BENEFITS PLAN MEMBERS' BILL OF RIGHTS)

What is the Health Benefits Plan Members' Bill of Rights?

The Health Benefits Plan Members' Bill of Rights is a District of Columbia law that gives any Member of a Health Maintenance Organization (HMO) or other Health Insurance Plan the right to appeal if they are denied coverage. This applies to any health insurance plan's decision that results in denial, reduction, limitation, termination, or delay in covered health care services by the HMO or health plan Insurer.

After following the Insurer's internal appeals process, the Member may appeal to the Office of Health Care Ombudsman and Bill of Rights. For more information, call 1-877-685-6391.

What is the first step to take if I am denied coverage?

When your HMO or Health Insurer renders an adverse decision, the HMO or Insurer must immediately give you the details of its internal appeals process so that you can file a grievance if you choose.

Follow the time lines established by your plan and the Office of Health Care Ombudsman and Bill of Rights for filing any appeals grievance or complaints. Record the dates you provided information to your plan, and keep a copy of any letters or forms you send to your plan.

What if the Insurer's Internal Appeals Process still results in an adverse action?

If the dispute is not resolved to your satisfaction, you have the right to contact the Office of Health Care Ombudsman and Bill of Rights for appropriate steps to file an external appeal.

To file an external appeal, you must submit a letter with proper documents within thirty (30) business days of receipt of the denial by the Insurer to: Office of the Health Care Ombudsman and Bill of Rights – 899 North Capitol Street, NE – 6th Floor – Washington, DC 20002

How does the Office of Health Care Ombudsman and Bill of Rights' appeals process work?

The Office of Health Care Ombudsman and Bill of Rights will review your documents, and will forward the information to an Independent Review Organization (IRO). After review, if the IRO determines you were improperly denied coverage of medically necessary covered services, it will recommend to the Office of Health Care Ombudsman and Bill of Rights the appropriate covered health services you should receive.

The Office of Health Care Ombudsman and Bill of Rights will forward copies of the recommendation to you and to your Insurer. The Insurer in turn is required to notify both you and the Office of Health Care Ombudsman and Bill of Rights' Coordinator as to whether it will accept the IRO's recommendations. If not, the Insurer must explain the reason for it rejection to you and to the Office of Health Care Ombudsman and Bill of Rights.

How much does it cost to file an appeal?

There is no cost to file an appeal.

How long after the final decision of my health benefits plan do I have to file an appeal?

The Member has thirty (30) business days after receipt of the health benefits plan's final decision to file an appeal with the Office of Heath Care Ombudsman and Bill of Rights.

How long does an appeal take?

Once the Office of Health Care Ombudsman and Bill of Rights receives and assigns your appeal, the IRO has thirty (30) business days to issue a final recommendation. In cases of urgent or emergency care the IRO has 72 hours to issue a recommendation.

How long after filing an appeal will I get a response?

The Office of Health Care Ombudsman and Bill of Rights is required to notify the Member within five (5) business days after receipt of an appeal whether or not the appeal has been accepted. In emergency or urgent medical care cases, the Office of Health Care Ombudsman and Bill of Right must notify the Member within twenty-four (24) hours. If the appeal is accepted, it is immediately referred to the Independent Review Organization. The IRO is to complete its review within thirty (30) business days, or seventy-two (72) hours in expedited cases.

If I appeal its decision, can the Insurer drop my coverage?

The HMO or Health Insurer must give you details on how to file an appeal with the Office of Health Care Ombudsman and Bill of Rights, and must not take any retaliatory action against you for pursuing your appeal rights.

Does this appeals procedure also apply to beneficiaries in Medicare or Medicaid Programs?

No. This program is not available to beneficiaries in the Medicare or Medicaid Programs as these programs have their own appeals procedures.

QUESTIONS?

If your question concerns the HMO/Medicaid Program, please call (202) 442-9094

If your question concerns the Fee-for-Service Medicaid Program, please call (202) 442-9094

If your question concerns the Medicare Program, please call 1-800-772-1213

If your question concerns the Grievances/Appeals (Health Benefits Plan Members' Bill of Rights Program), please call (1-877)-685-6391

CONFIDENTIALITY

The Health Care Ombudsman is an individual who holds all communications with those seeking assistance in strict confidence, and does not disclose confidential communications unless given permission to do so. The only exception to this privilege of confidentiality is where there appears to be imminent risk of serious harm.

How can you contact the Office of Health Care Ombudsman and Bill of Rights?

OFFICE OF HEALTH CARE OMBUDSMAN & BILL OF RIGHTS
899 NORTH CAPITOL STREET, NE
6TH FLOOR
WASHINGTON, DC 20002
(202) 724-7491 (OFFICE) * (202) 535-1216 (FAX) *
1-877-685-6391 (TOLL FREE NUMBER) * healthcareombudsman@dc.gov (E-MAIL)

***Member-International Ombudsman Association**