Wyoming
Notice of Grievance Procedures
in Accordance with 26-40-201.

Please read this notice carefully. If we have denied your request for a benefit, you have the right to have our decision reviewed by following the procedures outlined in this notice. An expedited review is available under circumstances where a delayed review might adversely affect your health. You also have the right to have our decision reviewed by a health care professional who has no association with us or the treating provider. You have the right to ask for a signed opinion of at least one clinical consultant who agrees with the denial and who is not our employee.

I. Definitions

"Adverse Determination" means a benefit denial or reduction based on medical necessity.

"Expedited Appeal" means an appeal which will have a faster response time because a delayed decision could have serious health impacts.

"Medical Necessity" means:

(A) A medical service, procedure or supply provided for the purpose of preventing, diagnosing or treating an illness, injury, disease or symptom and is a service, procedure or supply that:
- (I) Is medically appropriate for the symptoms, diagnosis or treatment of the condition, illness, disease or injury;
- (II) Provides for the diagnosis, direct care and treatment of the patient's condition, illness, disease or injury;
- (III) Is in accordance with professional, evidence based medicine and recognized standards of good medical practice and care; and
- (IV) Is not primarily for the convenience of the patient, physician or other health care provider.

(B) A medical service, procedure or supply shall not be excluded from being a medical necessity under this section solely because the service, procedure or supply is not in common use if the safety and effectiveness of the service, procedure or supply is supported by:
- (I) Peer reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE); or
- (II) Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act.

II. Designated Area Responsible For Complaint System and Receiving Complaints

	Quality Control Unit
Address:	P.O. Box 82657
	Lincoln, Nebraska 68501-2657
Phone:	877-897-4328 (Toll-Free)
Fax:	(402) 309-2579

III. Levels of Review

The following levels of review will be available to you:

Internal Review -- Standard Appeal
Internal Review -- Expedited
External Review -- Medical Necessity
External Review -- Contractual or Coverage

A. Internal Review Process for Standard Appeal

The internal appeals process may be initiated by you, an authorized person, or a provider or consultant acting on your behalf. You have at least thirty (30) days after receipt of an adverse determination or coverage denial to submit an appeal. A provider is not required to obtain written permission from you in order to formally request an appeal or file a grievance.

We will provide our review decision within forty-five (45) days of receipt of the appeal. Our review of an adverse determination will be conducted by at least one clinical consultant who did not participate in the initial review. Upon your request, a board eligible or certified specialist will be consulted as appropriate for the procedure(s). If authorized by you, and in accordance with state and federal privacy laws, relevant portions of the records will be reviewed. Providers may also submit additional information at that time.

Our response to an appeal of an adverse decision will include a reminder of your rights described in the first paragraph as well as your right to seek an External Review, (see Section C).

B. Expedited Internal Review

In cases where the timeframes for a Standard Appeal could jeopardize your health, we will expedite the review and provide a decision within seventy-two (72) hours after receipt of the request.

C. External Review -- Medical Necessity

You have a right to request an external review by an Independent Review Organization (IRO) if you disagree with our decision on medically necessity appeals. You have sixty (60) days following the receipt of our written decision to make this request, using a form that we will provide to you with our appeal decision letter.

The IRO will provide its written decision within forty-five (45) days, unless a request for an Expedited External Review has been made. An Expedited External Review decision will be provided within 72 hours.

In the event the IRO determines that benefits should be allowed, we will approve the benefit and notify you within five (5) days.

D. External Review -- Contractual or Coverage

You may bring any concerns about benefit denials based on contractual or coverage matters to the attention of the Department of Insurance at the address below:

Address:	Department of Insurance 106 East 6th Avenue Cheyenne, Wyoming 82002
Phone:	(307) 777-7401 (800) 438-5768 (In-state only)
Fax:	(307) 777-5895
Website:	http://insurance.state.wy.us