DISTRICT OF
COLUMBIA

HEALTH CARE
OMBUDSMAN
The Knowledge to Guide You

Users' Guide

Grievances and Appeals Commercial Insurers Annual Reporting

Overview

The District of Columbia (District) Department of Health Care Finance, Office of Health Care Ombudsman and Bill of Rights (OHCOBR), provides services to District consumers and persons who reside or are employed in the District. OHCOBR is guided by two legislative mandates, the Ombudsman's Program (District Law 15-331; District Official Code 7-2701.01) and the Health Benefit Plan Members Bill of Rights (District Law 19-546; District Code 44-301).

OHCOBR services focus on facilitating access to health benefits and ensuring those benefits meet the needs of the members enrolled with commercial insurers. OHCOBR responsibilities include:

- Addressing consumer complaints, facilitating the grievance and appeal process, and intervening with related parties on behalf of consumers to reach a quick and satisfactory resolution.
- Educating consumers about their rights and responsibilities concerning their health benefits and assisting consumers in enrollment in health plans for private and public health insurance programs.
- Guiding and advocating on behalf of members and helping people navigate the health care system by helping them to understand their health care coverage and supporting them in appealing health insurance decisions, including claims, medical procedures, and prescriptions that have been denied by insurance companies.

District Legislation states: "*An insurer's health benefits plan shall include an appeal system that provides for the presentation and resolution of appeals brought by members or member representatives.*"[1] Furthermore, the legislation requires "*A standardized method of recording, documenting, and reporting the status of all adverse benefit determinations and appeals, which includes the requirements that a health insurer maintain for 6 years records of all claims, and notices associated with the claims, grievances, appeals, and the review process, and limit access to patient-identifying information in those records in accordance with the Health Insurance Portability and Accountability Act of 1996, approved August 21, 1996 (Pub. L. No. 104-191; 110 Stat. 1936), and any other applicable patient confidentiality rules.*"

The Legislation requires the Director to develop "*a system for classifying and categorizing grievances and appeals that all insurers and independent review organizations will use when collecting, recording, and reporting grievance and appeals information.*"

In collaboration with the internal and external entities, the Director and OHCOBR develop the data collection instruments. These data collection instruments are updated and revised periodically; this Users' Guide is applicable to the latest version released.

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[1] https://code.dccouncil.us/us/dc/council/code/titles/44/chapters/3/

Technical Specifications

The technical specifications promote standardization by ensuring data collected and submitted by commercial insurers are: 1) valid, 2) can be used to measure compliance with the legislation, 3) can be used to advise the commercial insurers on the concerns brought by the members, and 4) allow for comparison between similar commercial insurers. The specifications provide direction to commercial insurers on how to collect, organize, validate, and submit the data electronically to the OHCOBR.

The technical specifications consist of the Data Dictionary, Data Flowchart, and Data Collection Tool.

Data Dictionary

A Data Dictionary is a collection of names, definitions, and attributes about data elements being captured in the data collection tool. It describes the meanings and purposes of data elements within the context of a project, provides guidance on interpretation, conventional meanings, and representation, and, in some circumstances, includes rules that guide data collection. The Data Dictionary serves several purposes:

- Allows for data consistency between the systems, including the data collection tool and systems used by the District
- Makes data analysis more meaningful and standardized across data submitters
- Provides meaningful descriptions for individually named data elements
- Increases confidence in the data, results, and decisions

The Data Dictionary developed by OHCOBR for grievance and appeal collection consists of five sections:

1. Organization Information – designed to gather the required information about each organization (commercial insurer) to submit the annual report on grievances and appeals
2. Member Information – intended to collect basic data about the member (claimant) who filed the grievance or on whose behalf the grievance was filed
3. Grievances and Appeal Information – developed to accumulate high level information about the grievance and appeal
4. Grievances and Appeal Background Information – focused on acquiring more detailed information about the specific grievance and appeal case
5. Provider Information – organized to compile basic but important information about the provided characteristics associated with the grievance and appeals

Each section includes relevant data elements and each data element is defined by specific attributes, as described in the table below:

Table 1: Data Dictionary Definitions

Data Element Name:	A unique name assigned to each data element.
Definition:	A statement that expresses the essential nature of a data element and its differentiation from all other data elements.
Value Domain:	The set of representations of permissible instances of the data element. The set can be specified by name (such as existing classification schemes like ICD-10), by reference to a source such as race and ethnicity, or by enumeration of the representation of the instances.
Maximum Length:	The maximum number of storage units (of the corresponding data type) necessary to represent the data element value. For a text field, the maximum length is the maximum number of storage units allowed.
Data Type:	An attribute that specifies the type of data that the field can hold: numeric, character, date/time.
Guide for Use:	Instructions or advice for the interpretation, use, or application of the data element.
Reporting:	Indicates if the data element is required for the reporting (R), conditional (C), or optional (O). If the data is defined as "R" it is required for submission, if the data is defined as "C" it is required based on specific conditions, and if the data is defined as "O" it is optional. The conditional data element is required in responses for some specific data elements but not all. The optional data elements should be included in the submission, if the information is available; however, the data can be submitted without that information.
Comments:	Any general note providing additional information about the data element including references to the Code of the District of Columbia relevant to the reporting. Chapter 3. Grievance Procedures for Health Benefits Plans.

The example of the data element with the attributes is included below:

Table 2: Sample Data Definition

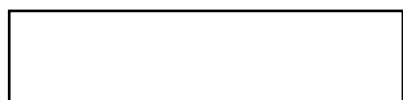| Data Element Name:	Organization Name (R)
Definition:	Name of commercial insurer organization
Value Domain:	N/A
Maximum Length:	100
Data Type:	Character
Guide for Use:	Name of the organization as listed in the Department of Insurance, Securities and Banking (DISB)
Reporting:	R
Comments:	"Insurer" means any individual, partnership, corporation, association, fraternal benefit association, hospital and medical services corporation, health maintenance organization, or other business entity that issues, amends, or renews group or individual health insurance policies or contracts, including health maintenance organization membership contracts in the District.

This specific data element, *Organization Name*, [Data Element name], defined as Name of commercial insurer organization [Definition], requires character values [Data Type], can be up to 100 characters in length [Maximum Length], should be the same as name of the organization as listed in the Department of Insurance, Securities and Banking [Guide for Use], is required for reporting to the OHCOBR [Reporting], and is based on the definition stated in the legislation [Comments]. This data element does not have permissible value set for the answer; therefore it is annotated as N/A [Value Domain].
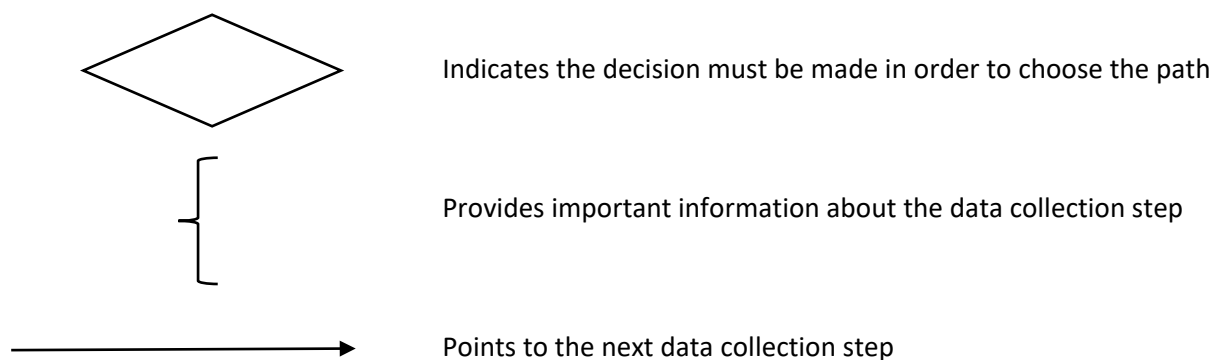
Data Flowcharts

A flow diagram (flowchart) maps out the flow of information for the process or system and uses specific symbols to convey the steps in the process. Flowcharts are designed to communicate information in a visual way and to present the logic to improve communication and understanding of the expected steps in the data collection process. It is a depiction of a logic operations to satisfy specific requirements (e.g., data collection). The OHCOBR developed the flowcharts specific to each section defined in the Data Dictionary. Some of the sections (Organization Information, Member Information, and Provider Information) have straightforward logic when the data are collected in the linear way with no decision points; however, the Grievances and Appeal Information and Grievances and Appeal Background Information sections require decisions to be made and to follow a specific path based on the answer in the prior step. The symbols used in the grievances and appeals data collection process include:
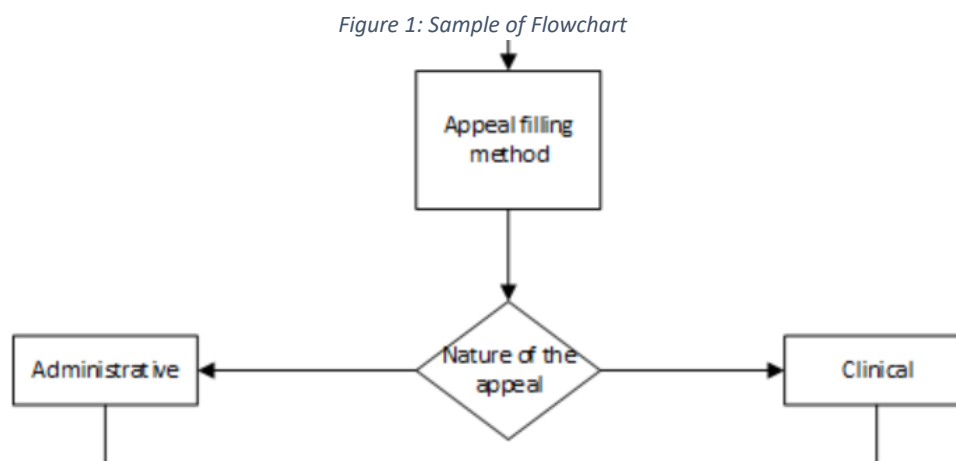
Marks start or end of the data collection process

Identifies the specific data collection step

Indicates the decision must be made in order to choose the path

Provides important information about the data collection step

Points to the next data collection step

The example of the flowchart is included below:

Figure 1: Sample of Flowchart

This specific flowchart sample identifies that after the data element *Appeal filling method* is completed, the next data element *Nature of the appeal* will require a decision to proceed; the *Administrative* and *Clinical* data elements lead to different paths to collect the appropriate information. If *Administrative* is selected in the *Nature of the appeal* data element, the information relevant to the administrative appeals will be collected; however, if *Clinical* is selected in response to *Nature of the appeal*, only information relevant to the clinical appeals will be required.

Data Collection Tool

The Grievances and Appeals Data Collection Tool (G&A Tool) is designed to collect the grievances and appeals data in a standardized format. This tool allows two approaches to gather the data: manually or via a file upload.

The G&A Tool is based on MS Excel and utilizes Excel Macros for data upload and validations of data for formatting and acceptable values. The tool includes capabilities to run initial validations on the collected

data before these data are submitted to OHCOBR for further processing. The G&A Tool consists of four spreadsheets.

- Instructions – includes instructions on how to use the G&A Tool, as well as the commands to upload and validate the data
- Summary – collects commercial insurers' specific information
- Data – captures grievances and appeals data to be included in the annual submission to the OHCOBR
- Validation Rules – includes information on the validation rules

*Figure 2: Data Collection Tool*
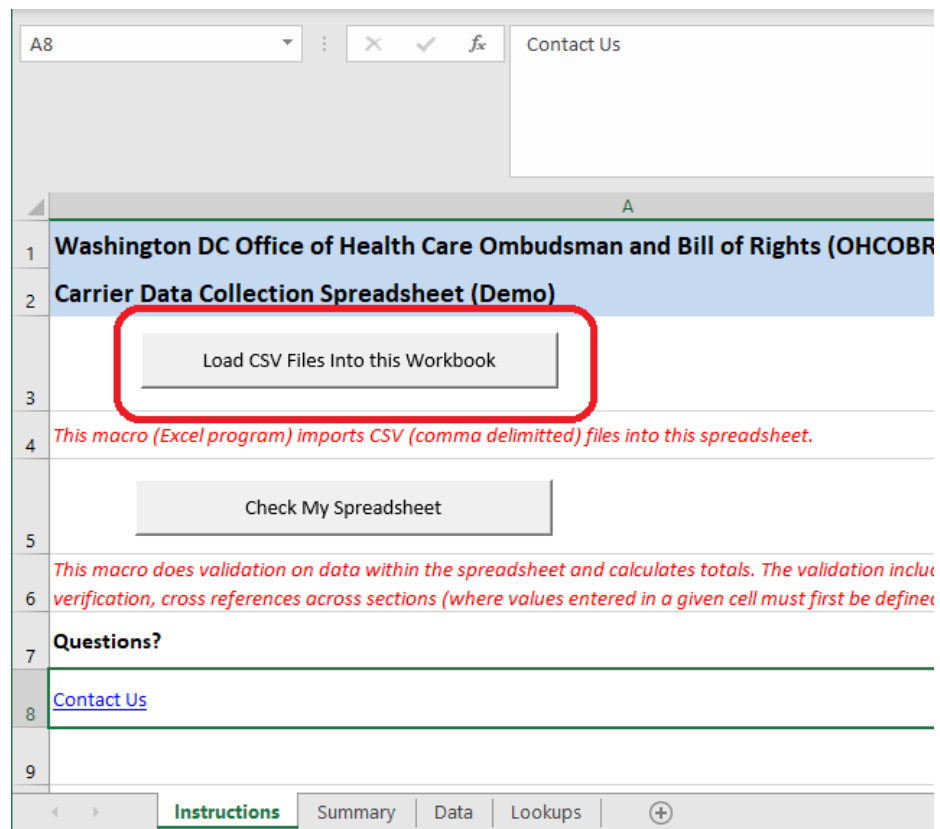
Submission to OHCOBR

The District established a secure process using a secure email to receive the grievances and appeals data from commercial insurers. The first time the data are submitted, an account for the commercial insurer will need to be established.

Registering for Department of Health Care Finance Secure Email Portal

This is a one-time setup of access to the Department of Health Care Finance Secure Email portal.

- Commercial insurer will provide a valid email address they want to use for accessing the Department of Health Care Finance Secure Email portal to the DC Health Care Ombudsman IT contact (Amani Alexander) at amani.alexander@dc.gov.
- Once the email address is received, the DC Health Care Ombudsman office will set up the account in the Department of Health Care Finance Secure Email portal and will send an email invitation to the email address provided by the commercial insurer.
- Once the invitation is received, the commercial insurer will follow the steps to configure their corresponding Department of Health Care Finance Secure Email portal account with a password of their choosing and complete the registration process.

Figure 3: Secure Invitation Example
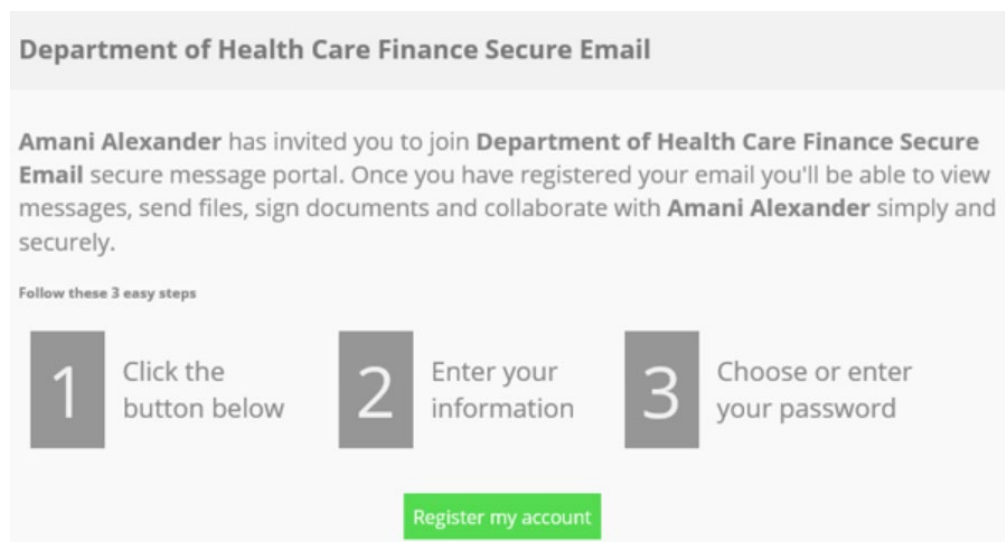


Submission of the Data

Once the commercial insurer has successfully completed registration, the user will log in to the Department of Health Care Finance Secure Email portal using the email address and the password used during registration. To send the data, the commercial insurer will select the Secure Email portal, send "Secure Message," and attach the "Secure File" to submit the data.

Figure 4: Selecting Secure Email Sample
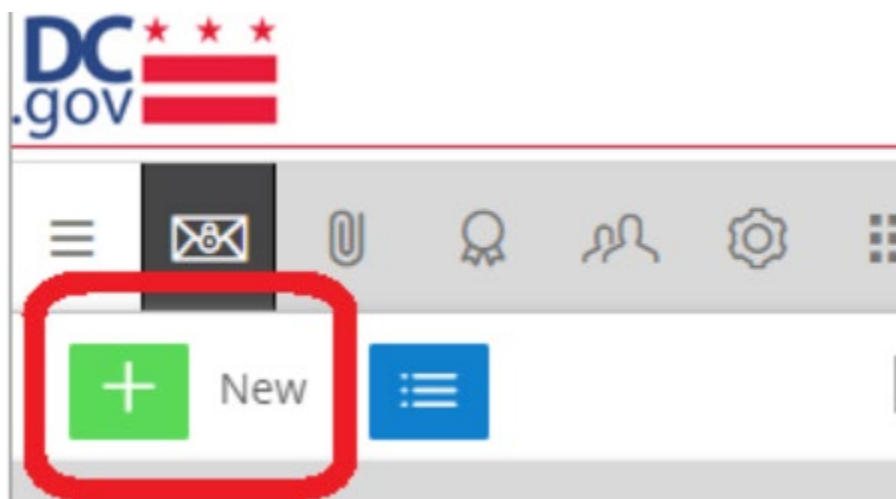
Guidance

To ensure the most accurate data collection, commercial insurers should be conversant with the District legislation mandating the process of grievances and appeals, as well as the process encompassing data collection and reporting to the District. The supporting specifications described in this Users' Guide, should guide the process of preparation and submission the appropriate data to the District.

Commercial insurers should start with familiarizing themselves with the Data Dictionary, especially the meaning and guide for use of each data element. Commercial insurers should then identify the appropriate data elements in their systems to support the data extract. Data extract should incorporate the business rules specified in Data Dictionary and depicted in the Data Flowcharts. After the data are extracted from the commercial insurers' systems, the information can be manually entered into the G&A Tool, or the data can be prepared for the load process using the G&A Tool upload feature. When the data are loaded, the validation process should be completed to ensure no formatting or valid values errors are identified. If no errors are present, the data can be submitted to the District.