Department of Consumer and Business Services
Division of Financial Regulation
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Grievance & Prior Authorization Annual Report

Annual report for 20__.

Due on June 30 for previous calendar year.
All domestic insurers offering health benefit plans must submit annual reports of grievances and appeals. All foreign insurers offering health benefit plans and who transacted $2 million or more in annual health benefit plan premiums in Oregon must submit annual reports of grievances and appeals.
ORS 743B.250, OAR 836-053-1000 to 836-053-1200.

Company name: _____ Date: _____

Contact person: _____ Title: _____

Phone: _____ Email: _____

Report the total number of grievances closed in the reporting year for each category outlined below. For each category, report the number of grievances in which the initial decision made by the company was upheld and the number in which the initial decision was reversed.

Nature of grievance categories OAR 836-053-1070(4)(a-k)	**Total number of grievances closed**	**Initial decision upheld**		**Initial decision reversed**	
		Number upheld	**Percentage upheld**	**Number reversed**	**Percentage reversed**
(a) Medical necessity					
(b) Experimental/investigational					
(c) Continuity of care					
(d) Access, referral, network, quality					
(e) Treatment setting and level of care					
(f) Otherwise covered, limits, exclusions					
(g) Not covered, general exclusions					
(h) Eligibility, cancelation, rescission					
(i) Quality of plan services (not clinical)					
(j) Emergency services					
(k) Admin issues & not otherwise covered					
Total closed					

Indicate the "Average days" between when a grievance is filed and the date final written determination is sent. When a grievance is also an appeal and it receives a second level of review or is sent for external review it should be counted in the respective rows below. The total count from the table below should match the total number of grievances closed in the table above. The percentage column calculation is the total number for the given row divided by the total number of all reported.

	Average days	**# of grievances**	**% of grievances**
Closed at first level on internal review			
Closed at second level on internal review			
Sent for external review			
Total	**N/A**		**N/A**

Prior authorization reporting 836-053-1070(6) - **All prior authorizations required under a health benefit plan are to be reported.** - **Items 1 through 7 are to be reported based on the date the prior authorization request was received.** - **Items 8 and 9 are to be reported based on the date the denial was reversed.** - **When reporting items 4 through 6, each initially denied prior authorization should be counted only once and reported under the most applicable reason for denial.**	
1. Total number of prior authorization requests received	
2. Total number of prior authorization requests initially approved	
3. Total number of prior authorization requests for which the entire requested item or service was not approved, but a specified portion of the requested item or service or a specified alternative item or service was approved	
4. Total number of prior authorization requests initially denied	
5. Total number of prior authorization requests denied due to lack of medical necessity	
6. Total number of prior authorization requests denied due to failure to provide additional clinical information	
7. Total number of prior authorization requests denied for all other reasons (provide specific reasons included in this count in the section below)	
8. Total number of prior authorization request denials reversed by internal appeals	
9. Total number of prior authorization request denials reversed by external reviews	