Health Plans

Manual: IU Health Plans
Department: CSC
Policy #003
Effective Date: 1/1/2015
Last update or issue date: 1/1/2021
Page(s) Including attachments

Medicare Advantage **Medicaid** **X Commercial**

IU Health Plans Fully-Insured Appeals Policy

I. Purpose

To provide a process for identifying, investigating and responding to member Administrative and Clinical Appeals in an appropriate and timely manner.

II. Scope

The implementation of this policy covers the handling of administrative and clinical appeals. The policy applies to Commercial Fully-Insured membership.

III. Definitions

Appeal: An oral or written request from a covered person, authorized representative or provider to change a previous decision made by IU Health Plans that was unresolved to the covered person's or provider's satisfaction at the complaint level.

Adverse Benefit Determination: means a determination for a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including a denial, reduction, termination or failure to make a payment based on the imposition of a preexisting condition exclusion, a source of injury exclusion, or other limitation on covered benefits.

Authorized Representative: An individual who the Covered Person has authorized in writing to represent or act on their behalf with regards to a claim or an appeal. An assignment of benefits does not constitute a written authorization for a Provider to act as an Authorized Representative of a Covered Person.

Expedited (Urgent) Appeal: A request to change an Adverse Benefit Determination made by the organization for care or service that has not been provided or care and service that are actively ongoing and to which the application of the time periods for making pre-service or post-service appeal decisions could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function if the care or service is not received.

External Review: A request for an independent (external) review organization to review the Final Adverse Benefit Determination that was made by the health plan through its internal appeal process.

Final Adverse Benefit Determination: An Adverse Benefit Determination that is upheld after the internal appeal process or an Adverse Benefit Determination for which the internal appeals process has been deemed exhausted.

Grievance: An oral or written request from a covered person, authorized representative or provider to change an adverse determination made by the organization for care of service.

Indiana Department of Insurance (IDOI): is an Indiana State Agency that regulates insurance companies operating in Indiana. Regulation is supported by law, and the IDOI reviews insurance application for regulatory compliance ensuring that Hoosiers are protected from improper business practices.

Post-service Appeal: A request to change an Adverse Benefit Determination made by the organization for care or service already rendered.

Pre-service Appeal: A request to change an Adverse Benefit Determination made by the organization for care or service that has not been provided to the member.

IV. Policy Statements

Members or authorized member representatives are directed to contact the IU Health Plans Customer Solution Center (CSC) to make suggestions, request information assistance, or express dissatisfaction. IU Health Plans will complete a comprehensive review and resolution of a member's dispute regarding the availability, delivery, appropriateness, medical necessity, or quality of health care services; the payment of a claim; or matters pertaining to the contractual relationship between the enrollee and the Plan. The member should have a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. This policy is available upon request to any member, provider or practitioner.

All Appeal records must contain: (1) The name of the member, provider and /or facility rendering service, (2) copies of all correspondence from the member, provider, or facility rendering service and the organization regarding the appeal, (3) Dates of appeal reviews, documentation of actions taken, and final resolution, and (4) Minutes or transcripts of appeal proceedings (if any).

All claims and appeals will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) will not be made based upon the likelihood or perceived likelihood that the individual will support a denial of benefits.

V. Procedures

A. Pre-service Appeals:

1. At the time a Pre-Service Appeal is received, the Appeal and Grievance Representative date stamps and documents the details of the Appeal in the internal tracking system.
2. If the requesting party is someone other than the member, obtains the necessary information and signature of the member designating an Authorized Representative to act on his/her behalf during the Appeal process.
3. The member or authorized representative is allowed at least 180 days after notification of the denial to file an appeal.
4. A Letter is sent to the Member within three (3) business days of receipt of the Appeal. The letter:
    a. Acknowledges the receipt of the member's Appeal.
    b. Offers the member the opportunity to be represented by someone of their choosing (including a practitioner, provider or member representative) as long as the designation is made in writing; and
    c. Advises the member of the following options:
        i. Members and/or their designated representative may request to appear before the Appeal Panel;
        ii. Members and/or their designated representative may submit oral or written comments, documents, or other information;
        iii. Members and/or their designated representative may request copies of all documents relevant to the member's Appeal;
        iv. Members and/or designated representatives who cannot appear in person at the hearing may communicate with the Appeals Panel via conference calling.
        v. When a member and/or the designated representative does not wish to participate in a hearing, the Appeal Panel will review the appeal documentation and render a decision.
5. The Appeal and Grievance Representative contacts the appropriate IU Health Plans (Plan) personnel or the Practitioner's office for any additional information pertinent to the Appeal in order for the Plan to conduct a full investigation of the substance of the appeal.
6. The Appeal and Grievance Representative will forward the complete case file to the appropriate reviewer(s) requesting a written response within five (5) business days.
7. The member will be provided with a minimum of 72 hours-notice of the scheduled Appeal Panel hearing when applicable. The member has the right to waive participation in a hearing.
8. No members of the Appeal Panel may be involved in any previous determination or be the subordinates of any person involved in the initial determination.
9. Appeal Panel must include one (1) or more individuals who:
    a. Director/Associate Medical Director
    b. Medical Management
    c. Member Services
    d. Quality Management
    e. Claims

f. Marketing
g. Provider Relations
h. Pharmacy

10. For Appeals involving any clinical issues including Appeals with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the IU Health Plans Medical Director will consult a Credentialed Board Certified specialist of the same or similar specialty as to the clinical question during the review of the Appeal. The specialist:
    a. Will have knowledge of the medical condition, procedure or treatment at issue;
    b. Will be in the same licensed profession as the practitioner who proposed, refused or delivered the health care procedure, treatment or service;
    c. Is not involved in the matter giving rise to the or any previous review processes; and
    d. Must not have a direct business relationship with the Covered Person (enrollee) or the practitioner who previously recommended the health care procedure, treatment or service giving rise to the Appeal.
11. Any new or additional evidence considered, relied upon, or generated by (or at the direction of) IU Health Plans in connection with a claim will be provided to the member free of charge. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Adverse Benefit Determination is required to be provided in order to give the member a reasonable opportunity to respond prior to that date.
12. The Appeal will be completed and the member notified of the decision within thirty (30) days of the request. Notification includes:
    a. The decision, in clear terms, with the benefits or clinical rationale;
    b. A statement of the reasons, policies, and procedures that are the basis for the decision;
    c. Notice of the covered individual's right to further remedies allowed by law, including the right to external grievance review by an independent review organization;
    d. The department, address, and telephone number through which a covered individual may contact a qualified representative to obtain more information about the decision or the right to an external grievance review.
13. The Appeal and Grievance Representative will document the substance of the Appeal, including all actions taken during the review, appeal hearing, and all aspects of clinical care involved in the case.

B. Urgent/Expedited Appeal

1. An urgent /expedited appeal will be provided for any appeal related to an illness, a disease, a condition, an injury or a disability that would seriously jeopardize the Covered Person's:
    a. Life or health;
    b. Ability to reach and maintain maximum function; or
    c. Requires medical service within 48 to 72 hours.

2. Urgent/Expedited Appeals may include Concurrent Care reviews as appropriate. Concurrent Care reviews concern an Adverse Benefit Determination of a request for benefits affecting an ongoing course of treatment taking place over a period of time or a number of treatments. Urgent Care Appeals/Expedited Appeals must be offered to all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility.
3. Upon written or oral receipt of an urgent care appeal/expedited appeal from a member or a member designated authorized representative acting on behalf of the member, the Appeal and Grievance Coordinator:
    a. Contacts the Clinical Reviewer for determination that a request meets the criteria for an urgent care appeal/expedited appeal. The determination as to whether a claim involves urgent care will be determined by the attending provider, and the Clinical Reviewer must defer to such determination.
    b. Documents the urgent care appeal/expedited appeal into the internal tracking system; and
    c. Makes a copy and forwards it to the Clinical Reviewer
    d. Sends written confirmation of Plan decision to the member, member representative, or practitioner filing the appeal.
4. The Clinical Reviewer:
    a. Documents the urgent care appeal/expedited appeal into the Medical Management appeal review tracking system;
    b. Collects and refers all documentation to a Medical Director not involved in the initial decision nor a subordinate of that individual, who confers with appropriate specialists as indicated, investigates all submitted information, and makes a decision on the urgent care appeal/expedited appeal;
    c. Notifies the member, member representative, or practitioner verbally of the Medical Director decision as expeditiously as the medical condition warrants, but no more than seventy-two (72) hours from the receipt of the urgent care appeal/expedited appeal;
    d. Within (1) business day of providing verbal notification of the decision, returns the urgent care appeal/expedited appeal case file to the Appeal and Grievance Coordinator for written confirmation of the Plan's decision to the member, member representative, or practitioner and
    e. Updates the Medical Management appeal tracking system.
5. Any new or additional evidence considered, relied upon, or generated by (or at the direction of) IU Health Plans in connection with a claim will be provided to the member free of charge. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is required to be provided in order to give the member a reasonable opportunity to respond prior to that date.
6. Notification Letters include:
    a. The decision, in clear terms, with the benefits or clinical rationale;

b. A description of the next level of appeal, External Review by Independent Review Organization and any relevant written instructions;
c. A statement of the pertinent facts of the Appeal;
f. A reference to the provisions that support the decision such as the Group Service Agreement or contract;
g. If applicable, a copy of or a statement that an internal rule, guideline or protocol was relied upon and is available upon request;
h. Statement of any additional information that could be helpful in the outcome of the Appeal; and
i. Instructions for requesting a written statement of the clinical rationale and review criteria for cases involving a denial of medical services;
j. Notification about further appeal rights; and
k. With respect to any Adverse Benefit Determination or Final Adverse Benefit Determination, the notice must also include:
    i. Information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code, and its corresponding meaning;
    ii. The denial code and its corresponding meaning;
    iii A description of the standard that was used in denying the claim, including for Final Adverse Benefit Determinations, a discussion of the decision; and

C. Post-Service Appeal

1. At the time an Appeal is received, the Appeal and Grievance Representative notifies the member in writing within three (3) business days that his/her Post-Service Appeal has been received;
2. If the requesting party is someone other than the member, obtains the necessary information and signature of the member designating an Authorized Representative to act on his/her behalf during the Appeal process.
3. Provides the member or designated member representative with information concerning the review process;
4. Provides the member or designated member representative with the name and direct phone number of the IU Health Plans Representative who will be handling their review;
5. Enters the Appeal into the internal tracking system and does the following:
    a. Contacts the appropriate IU Health Plans (Plan) personnel or the Practitioner's office for any additional information pertinent to the Appeal;
    b. Sends internal tracking information and all additional documentation received from the member and/or providers to appropriate IU Health Plans personnel for review of the case file requesting a response within five (5) business days;
    c. Submits the Appeal, with all available, relevant documentation that has been acquired, for a decision, to an individual not involved in any previous

determination; this usually is reviewed by the Medical Director for a clinical Appeal, or the Director of Member Services for a non-clinical Appeal. Neither individual may have been involved in any previous determination.

d. Documents the substance of the Appeal, including all actions taken during the review and all aspects of clinical care involved in the case.
e. Sends decision letter to member or designated representative.

6. Any new or additional evidence considered, relied upon, or generated by (or at the direction of) IU Health Plans in connection with a claim will be provided to the member free of charge. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Adverse Benefit Determination is required to be provided in order to give the member a reasonable opportunity to respond prior to that date.
7. The Appeal will be completed and the member notified of the decision within thirty (30) days of the request
8. Notification Letters include:
    a. Acknowledges the receipt of the member's Appeal.
    b. Offers the member the opportunity to be represented by someone of their choosing (including a practitioner, provider or member representative) as long as the designation is made in writing; and
    c. Advises the member of the following options:
        i. Members and/or their designated representative may request to appear before the Appeal Panel;
        ii. Members and/or their designated representative may submit oral or written comments, documents, or other information;
        iii. Members and/or their designated representative may request copies of all documents relevant to the member's Appeal;
        iv. Members and/or designated representatives who cannot appear in person at the hearing may communicate with the Appeals Panel via conference calling.
        v. When a member and/or the designated representative does not wish to participate in a hearing, the Appeal Panel will review the appeal documentation and render a decision.
9. The Appeal and Grievance Representative will document the substance of the Appeal, including all actions taken during the review and all aspects of clinical care involved in the case and close the file.

D. External Review

1. If a member is not satisfied with the Appeal decision, the member may contact the plan to proceed to the External Review process. A member must exhaust the internal appeal process before requesting an External Review, unless (a) IU Health Plans waives the exhaustion requirement; (b) IU Health Plans fails to comply with the requirements of the internal appeals process, except for failures that are based on de minimis violations; or (c) the member requests a simultaneous expedited internal and external appeal. The request for External

Review must be received within 120 calendar days of the receipt of the Plan's decision letter regarding the appeal.

2. In the event that IU Health Plans fails to comply with the requirements of the internal appeals process but does not consider the internal claims and appeals process to be deemed exhausted, the member may request a written explanation of the violation, which IU Health Plans will provide within 10 days, including a description of the bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. In the event that the Independent Review Organization (IRO) rejects the claimant's review on this basis, the plan must provide the member with notice of the opportunity to resubmit and pursue an internal appeal, which notice must be sent within 10 days after the external reviewer rejects the claim.
3. If an External Review is requested by someone other than the member, the member is contacted to obtain the necessary information and signature on the Designation of Representation form to act on the member's behalf during the External Appeal review process.
4. The member is eligible for External Review if their Appeal was for:
    a. An adverse utilization review determination;
    b. An Adverse Benefit Determination that involves medical judgment, including but not limited to medical necessity, appropriateness, health care setting, level of care, or effectiveness;
    c. A determination that a proposed service is Experimental or Investigational (of a service proposed by the treating physician); or
    d. A rescission of coverage, regardless of whether or not the rescission has any effect on any particular benefit.
5. The IRO will rely on appropriate clinical expertise, will not have any direct financial interest in the health plan or in the outcome of the external appeal, and may not have been involved in the original determination under appeal.
6. Costs associated with the External Review process will be paid by the Plan.
7. Upon receipt of the External Review request by the Appeal and Grievance Coordinator, the External Review request is date-stamped and substance and actions taken are documented in the internal tracking system.
8. The Appeal and Grievance Coordinator will forward a copy of all documentation to the IRO for review and decision.
9. The Appeal and Grievance Coordinator will select the IRO to conduct the External Review from the Independent Review Organization Rotation Assignment List on the Indiana Department of Insurance website: www.in.gov/idoi. The Review Organization selection will be done sequentially without repeating review organizations until each organization on the list has been selected.
10. A member may submit to the IRO additional information in writing that the IRO must consider when conducting the external review, and the member will be notified of that right. The IRO must allow the claimant at least 5 business days to submit any additional information and any additional information must be forwarded to the Plan within one business day of receipt by the IRO.

11. The IRO has seventy-two (72) hours to reach a determination on Urgent/Expedited Appeals and fifteen (15) days to reach a determination on standard Appeals. The IRO decision is binding on the member and the Plan, except to the extent that other remedies are available under state or Federal law.
12. The IRO will notify the Plan and the enrollee of the determination within seventy-two (72) hours after and expedited external appeal is filed.
13. Once the Appeal and Grievance Coordinator receives a copy of the determination from the IRO, the appropriate action is taken and a copy of the documentation placed in the member's file.
14. If at any time during an External Review, the enrollee submits information to the Plan that is relevant to the Plan's resolution and was not considered in the previous Appeal reviews:
    a. The Plan will reconsider the previous resolution based on the additional information.
    b. The IRO will cease the external review process until the reconsideration by the Plan is completed.
    c. The Plan will notify the enrollee of the Plan's decision within seventy-two (72) hours after the information is submitted for a reconsideration related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the enrollee's
        i. life or health; or
        ii. ability to reach and maintain maximum function; or
        iii. within fifteen (15) business days after the information is submitted for a reconsideration of a standard Pre-service or Post-service Appeal.
    d. If the reconsideration decision is adverse to the enrollee, the enrollee may request that the IRO resume the external review process.
15. The IRO must maintain written records in compliance with all applicable laws and for at least three years.

VI. References/Citations

29 CFR § 2560.503-1
29 C.F.R. § 2590.715-2719
45 C.F.R. § 147.136
PPACA Legislation
IC 27-8-28
NCQA Standards ME7
NCQA Standards UM8

VII. Forms/Appendices

None

VIII. Responsibility

Grievances and Appeals