



HOPP # 58

Policy Name:	Member Complaint and Appeal Policy
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Policy Information:

Policy #	C.A. 001	Originating Department	Complaints, Grievances and Appeals
Revision	13.0		
Category		Business Owner(s)	Melissa Alexander
Effective Date	February 5, 2004	Policy Status	Approved
Approval Date	June 2, 2015	Date last reviewed	March 4, 2014
Implementation Date	September 2, 2015		

Revision History:

Date	Revision	Reason
February 5, 2004	1.0	Replacement
April 18, 2005	2.0	Annual Review
November 1, 2005	3.0	Revision
May 1, 2006	4.0	Revision
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October 5, 2010	9.0	Revision
January 24, 2012	10.0	Revision
January 29, 2013	11.0	Revision
March 4, 2014	12.0	Revision
June 2, 2015	13.0	Revision

Type	<input type="checkbox"/> New	<input checked="" type="checkbox"/> Revision	<input type="checkbox"/> Clarification	<input type="checkbox"/> Replacement
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Applies To:

Medical Products	HMO based Medical Products	Medicare Advantage Products	Traditional Medical Products	Dental Products	Pharmacy Products	Group Insurance Products	Systems	Other
<input checked="" type="checkbox"/> All <input type="checkbox"/> None <input type="checkbox"/> Medical Products	<input checked="" type="checkbox"/> All <input type="checkbox"/> None <input type="checkbox"/> HMO <input type="checkbox"/> Open Access HMO <input type="checkbox"/> USAccess <input type="checkbox"/> QPOS <input type="checkbox"/> Choice POS <input type="checkbox"/> Health Network Option (HNO)	<input type="checkbox"/> All <input checked="" type="checkbox"/> None <input type="checkbox"/> Medicare <input type="checkbox"/> Medicare Prescription Drug (Part D)	<input checked="" type="checkbox"/> All <input type="checkbox"/> None <input type="checkbox"/> Traditional Choice <input type="checkbox"/> Open Choice <input type="checkbox"/> Aetna HealthFund <input type="checkbox"/> Open Choice <input type="checkbox"/> Managed Choice <input type="checkbox"/> Open Access <input type="checkbox"/> Managed Choice	<input checked="" type="checkbox"/> All <input type="checkbox"/> None <input type="checkbox"/> DHMO <input type="checkbox"/> Indemnity <input type="checkbox"/> PPO	<input checked="" type="checkbox"/> All <input type="checkbox"/> None	<input type="checkbox"/> All <input checked="" type="checkbox"/> None <input type="checkbox"/> Traditional Short Term Disability <input type="checkbox"/> Traditional Long Term Disability <input type="checkbox"/> Managed Disability <input type="checkbox"/> ADS <input type="checkbox"/> Coordinated Disability <input type="checkbox"/> Group Long Term Care	<input type="checkbox"/> All <input type="checkbox"/> None <input checked="" type="checkbox"/> HMO <input checked="" type="checkbox"/> ACAS <input type="checkbox"/> Aecclai m s <input type="checkbox"/> MCS <input checked="" type="checkbox"/> CATS <input checked="" type="checkbox"/> Target <input checked="" type="checkbox"/> MSW <input checked="" type="checkbox"/> Data Migrator <input checked="" type="checkbox"/> E-tums <input checked="" type="checkbox"/> ATV	<input checked="" type="checkbox"/> All <input type="checkbox"/> None <input type="checkbox"/> Discou nt Plans

	<input type="checkbox"/> Innovation Health <input type="checkbox"/> Coventry Health Care Inc.		<input type="checkbox"/> Aetna HealthFund Open Access Managed Choice <input type="checkbox"/> Elect Choice <input type="checkbox"/> Open Access Elect Choice <input type="checkbox"/> Aetna HealthFund Open Access Elect Choice <input type="checkbox"/> Choice II <input type="checkbox"/> Flexible Spending Account <input type="checkbox"/> Affordable Health Choices (Aetna Voluntary Plan (AVP), formerly SRC) <input type="checkbox"/> Blanket Health (Aetna Student Health) <input type="checkbox"/> Aexcel <input type="checkbox"/> Innovation Health <input type="checkbox"/> Coventry Health Care Inc.			<input type="checkbox"/> Basic and Supplemental Group Life <input type="checkbox"/> Portable Supplemental Term Life <input type="checkbox"/> Group Universal Life	<input checked="" type="checkbox"/> Aetna Strategic Desktop (ASD) <input checked="" type="checkbox"/> Navigator <input checked="" type="checkbox"/> IDX	
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Funding Arrangement	Group Arrangement:
<p>Fully Insured (includes split funding arrangements)</p> <ul style="list-style-type: none"> Aetna Fiduciary <p>ASC (Self Insured)</p> <ul style="list-style-type: none"> Aetna Fiduciary - Complaints and Appeals Plan Sponsor Fiduciary – Complaints (Note: Policy is not applicable when appeals are handled by the Plan Sponsor) 	<input checked="" type="checkbox"/> All <input type="checkbox"/> Employer Group <input type="checkbox"/> Blanket Health <input type="checkbox"/> Individual Conversion

Section I – General Standards

Purpose

The purpose of this policy is to establish standards across all affected functional areas for the evaluation, monitoring and resolution of verbal and written complaints and appeals submitted by Aetna members and/or their authorized representative.

Policy Statement

All member complaint and appeal investigation and resolution activities must be conducted in accordance with the standards outlined within this policy and as required by any related policies and/or procedures.

Responsibility

The Complaints, Grievances & Appeals Team is responsible for developing member complaint and appeal policies and procedures. The Resolution Teams are responsible for processing cases in accordance with these policies and procedures and any applicable state or federal law. The Resolution Teams will consult with Business Unit Subject Matter Experts (SME) as appropriate.

Confidentiality

All complaint and appeal resolution team members are expected to follow the confidentiality guidelines in the Aetna Code of Conduct and the Privacy and Information Security Policies. In addition, all complaint and appeal resolution team members are required to take updated versions of these programs in accordance with company directives.

Record Retention

All documentation related to and created in response to complaints and appeals will be retained for a minimum of 10 years or longer as required by state or federal law or regulation, or current company policy.

Quality Review

All complaints and appeals are subject to the Quality Audit Program. A sample of closed files is reviewed each month to ensure the case was processed in accordance with this Policy and related procedures.

Application of State or Federal Laws and Regulations

To the extent that this policy, plan documents and/or plan sponsor performance guarantees vary from the applicable state or federal laws and/or regulations, the requirements of the law or regulation are adopted and supersede Aetna's written policy for those cases affected by the law. Aetna's law department makes the final determination when there is any question as to the applicability of a law.

Application of Plan Documents

To the extent that this policy varies from the Certificate of Coverage (COC), Summary Plan Description (SPD), or the Summary of Coverage (SOC) of an individual, the requirements of the COC, SPD or SOC supersede Aetna's written policy for those affected. However, if a regulatory requirement is more stringent than the COC, SPD or SOC, the regulatory requirement will be followed.

Application to Plan Sponsor Performance Guarantees

To the extent that this process varies from any Plan Sponsor performance guarantees, the performance guarantee will be followed. However, if an applicable regulatory requirement is more stringent than the performance guarantee, the regulatory requirement will be followed. Performance guarantees are managed through the Standards Management Unit.

Counsel Fees

Aetna has no responsibility to pay counsel fees or any other fees or costs incurred by a member pursuing a complaint or appeal.

Continuation of Coverage

Post-Service Appeals, where the service has been rendered and the claim was processed by the previous carrier, will be handled by the previous carrier.

If a pre-service denial was issued by a previous carrier and the service has not been rendered prior to the Aetna effective date, a new pre-certification request should be submitted to Aetna for consideration.

Roles

For complete summary, refer to the [Roles and Responsibilities Summary](#) and [Resolution Team Routing Guide](#) located on the CG&A website.

Section II – Definitions¹

Adverse Benefit Determination	<p>A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.</p> <p>This also includes rescissions of coverage for all types of plans and declination of coverage for individual plans only.</p>
Appeal	<p>A verbal or written request by a member or a member's authorized representative, requesting a change in the Initial Determination decision. This includes but is not limited to requests related to the following:</p> <ol style="list-style-type: none"> (1) Certification of health care services; (e.g., pre-certification, concurrent review, retrospective services) (2) Claim payment (3) Plan interpretation (4) Benefit determinations (5) Eligibility (including issues where termination of coverage precludes the member from having services) <p>Disputes regarding the member liability related to discount programs are not eligible for appeal.</p> <p>Aetna has three categories of appeals, each defined herein, that are addressed by the Member Complaint and Appeal Policy as follows:</p> <ol style="list-style-type: none"> (1) Expedited; (2) Pre-Service; and (3) Post-Service
Appeal - Level One	An oral or written request by a member or a member's authorized representative requesting a change in the initial determination decision.
Appeal - Level Two	An oral or written request by a member or a member's authorized representative requesting a change in the Level I appeal decision.
Claim for Benefits	<p>A benefit request which includes:</p> <ul style="list-style-type: none"> • Bills submitted for services rendered, • Requests for pre-certification of services where the plan requires such pre-certification. <p>An inquiry regarding eligibility of a member or whether a particular service is covered under the plan of benefits is not a claim for benefits unless</p> <ul style="list-style-type: none"> • the service to be rendered requires approval of the benefit in advance of obtaining medical care (pre-certification) <u>and</u> • the inquiry names the specific claimant, specific medical condition or treatment, and the service or product for which a precertification is requested.
Complaint	Any oral or written expression of dissatisfaction/concern, other than an

¹ Patient Management related definitions are summaries of the definition from the PM policy

	<p>appeal, by a member or a member's authorized representative regarding services provided by Aetna, a health care professional or a vendor, including but not limited to:</p> <ul style="list-style-type: none"> • Potential quality of care by a participating health care professional • Quality of administrative service provided by a participating health care professional • Quality of administrative service provided by Aetna • Use of his/her protected health information • A plan benefit, billing, eligibility or contract provision that does not involve a request to review a denied claim • Issues regarding premiums excluding eligibility related issues.
Concurrent Care	An ongoing course of treatment to be provided over a period of time or number of treatments. Concurrent care includes services provided both inpatient and outpatient.
Concurrent Review	<p>Concurrent review encompasses those aspects of Patient Management that take place during the provision of services at an inpatient level of care or during an ongoing outpatient course of treatment.</p> <ul style="list-style-type: none"> • Provider requests for extension of coverage² for a course of clinically urgent inpatient or outpatient treatment received prior to the expiration of the current certified number of days/visits/treatments are handled expeditiously as an urgent concurrent review request. • Provider requests for routine extension of an ongoing outpatient course of treatment are handled as a new precertification request. <p>Note: Aetna is required to continue previously approved concurrent services during the course of an appeal review until the determination is made.</p>
Executive Appeal	An appeal sent to Aetna's President, CEO or Chairman, one of their direct reports, to a Board of Director member, to a Segment Head or to the Head of Service Operations, to a Legislative Representative or the Better Business Bureau.
Executive Complaint	A complaint sent to Aetna's President, CEO or Chairman, one of their direct reports, to a Board of Director member, to a Segment Head or to the Head of Service Operations, to a Legislative Representative or the Better Business Bureau.
Expedited Appeal	An oral or written appeal of a decision involving urgent care. Post service issues are not eligible for an expedited process.
Expedited Complaint	Any oral or written expression of dissatisfaction/concern by a member or a member's authorized representative, regarding an urgent matter, (i.e. member complains about inability to get a timely appointment when they feel their health could be jeopardized).
External Review	<p>Independent, third party external review of coverage denials based upon Aetna's determination that the proposed or rendered service or supply is not medically necessary or is experimental/investigational in nature.</p> <p>Note: Under current Federal Regulation in effect until 2016, denials based on medical judgment are included in this definition.</p>
Health Care Professional	A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state or federal law. Examples include physicians, dentists, podiatrists, independent nurse practitioners, and institutional providers and suppliers of healthcare services including behavioral health care organizations.

² For these purposes, "coverage" means either the determination of (i) whether or not the particular service or treatment is a covered benefit pursuant to the terms of the particular member's benefit plan, or (ii) where a provider is required to comply with Aetna's Patient Management programs, whether or not the particular service or treatment is payable under the terms of the provider agreement.

Initial Determination	The first decision made for prospective or post-service care or services.
Medical Judgment	Issues related to medical necessity, experimental and investigational, cosmetic and level of care. It can also include the type of clinical review that helps determine if something is subject to a contractual denial (e.g., speech therapy).
Member's Authorized Representative	<p>An individual representing the member in the appeal or complaint process. For appeals an individual must satisfy at least one of the following requirements. For complaints, an individual must satisfy requirement (a) or (b)</p> <ul style="list-style-type: none"> (a) The member has given express written or verbal consent for the individual to represent the member's interests. . (b) The individual is authorized by law to provide substituted consent for a member (e.g., parent of a minor, legal guardian, foster parent, someone holding a power of attorney). (c) For pre-service, urgent care or concurrent care claims only, the individual is an immediate family member of the plan member (e.g., spouse, parent, child, sibling). (d) For pre-service, urgent care or concurrent care claims only, the individual is a primary caregiver of the member. (e) For pre-service, urgent care or urgent concurrent care claims only, the individual is a health care professional with knowledge of the member's medical condition (e.g., the treating physician). <p>Exceptions to this process require approval of Regional Counsel.</p>
One Step Resolution	When a Complaint or Appeal is entered into Complaint Tracking System and all information needed to handle and close the case is available, the case can be completed using the One Step Resolution process.
Overturn	A reversal of the initial determination or subsequent appeal determination. This may or may not result in the release of additional benefits.
Partial Uphold	A reversal of a portion of the initial determination or subsequent appeal determination. This may or may not result in the release of additional benefits.
Post-Service	<p>Any claim for benefits that are not pre-service. Post service issues are not eligible for an expedited process.</p> <ul style="list-style-type: none"> • Pharmacy appeals where the service doesn't require preauthorization are considered post service appeals. Preauthorization for pharmacy includes step therapy and prior authorization requirements. There are specific lists for the drugs included in these requirements. • Post service appeals also include rescissions of coverage for all plan types and declinations of coverage for individual plans only. <p>For Pre-Service requests, when the service is rendered during the course of the appeal process, the appeal is still completed within the timeframe for resolution of a pre-service appeal.</p> <p>For pre-Service requests that have services rendered prior to subsequent appeal requests, the next level of review is handled as a new post service level 1 appeal.</p> <p>If there is an adverse determination and the service has been rendered but we have not received a claim, this is considered a post service appeal. The claim denial is not necessary for an appeal to be a post service appeal.</p>

Potential Quality of Care Concern	A concern raised by anyone internal or external to the health or dental plan that requires investigation as to whether the competence ³ or professional conduct of an individual Aetna network practitioner, organizational provider, or vendor adversely affects, or could adversely affect, the health or welfare of a member.
Pre-Certification	<p>The prospective process of collecting information prior to inpatient admissions and performance of selected ambulatory (i.e., outpatient) procedures and services that appear on Aetna's pre-certification list, plan sponsor specific precertification list or SPD and the making of an initial determination of benefits for those care or services.</p> <p>Services on the precert list that require notification only are not denied on initial precertification and therefore, generally do not qualify as preservice denials.</p>
Pre-Determination	<p>A benefit request made prior to the services being rendered for coverage of care or services that are not listed on the national pre-certification list.</p> <p>Note: Pre-determinations are not considered claims for benefits under the DOL regulations.</p> <p>If the service is rendered during the timeframe of the receipt of the pre-determination request, the request for care or services is no longer considered a pre-determination.</p> <p>Predeterminations are not eligible for appeal. However, once the service is rendered; the decision can be appealed but it is no longer considered a pre-determination. It follows the post service claim denial path.</p>
Pre-Service	<p>A benefit request of coverage for care or services where:</p> <ul style="list-style-type: none"> • The terms of the plan state that Aetna must approve in whole or part the benefit in advance of the member obtaining the service (i.e., services require pre-certification), and • The services have not been rendered <p>Appeals of pre-service are categorized and managed through the Aetna pre-service appeal process.</p> <p>If the service is rendered during the course of the appeal process, the appeal is still completed within the timeframe for resolution of a pre-service appeal.</p> <p>If the service is rendered prior to subsequent appeal requests, the next level of review is handled as a new post service level 1 appeal.</p> <p>If there is an adverse determination and the service has been rendered but we have not received a claim, this is considered a post service appeal. The claim denial is not necessary for an appeal to be a post service appeal.</p>
Prospective	Care or services not yet rendered. Prospective services are categorized as either a Pre-Determination or Pre-Service (Pre-certification).
Protected Health Information (PHI)	Information created or reviewed by Aetna that relates to the past, present or future physical or mental condition of a member; or to the provision of or payment for his/her health care. PHI is information that either identifies, or there is reason to believe that it could be used to identify a member
Quality of Service	A concern raised by anyone internal or external to the health or dental

³ For purposes of this policy, the term "competence" includes an assessment of clinical management skills.

Complaint	plan indicating that the service the member received was not to the member's satisfaction. Examples include, but are not limited to rude office staff, unsanitary office, long travel distances or an issue with services provided by Aetna (e.g. Customer Service and Aetna Specialty Pharmacy).
Regulatory Complaint	A complaint that originates from any state or federal agency concerning Aetna's products and services.
Relevant Documents	A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information <ul style="list-style-type: none"> (i) Was relied upon in making the benefit determination; or (ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; or (iii) Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination; or (iv) In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.
Rescission of Coverage	A rescission of medical coverage means that the member's coverage has been terminated back to their original effective date, as if they never had coverage with Aetna. A rescission is done only after a lengthy internal investigation which involves medical record review, communication with the member, establishment of treatment and medical history timelines, etc., the outcome of which demonstrates that the member knowingly committed fraud or intentionally misrepresented his/her health status which materially affected our evaluation of the risk.
Retrospective Review	Retrospective review is the process of reviewing coverage ⁴ requests for initial certification: <ul style="list-style-type: none"> • After the service has been provided or; • When the member is no longer inpatient or receiving the service. <ul style="list-style-type: none"> ○ A review initiated while a member is hospitalized is considered a concurrent review. ○ A review as the result of a precertification adverse coverage determination or claim denial is considered an appeal. <p>The process of reviewing coverage requests for care or services requiring precertification after the care or service has been provided (i.e., when the member is no longer inpatient or receiving the care / services). Retrospective review includes making coverage determinations for the appropriate level of service consistent with the member's needs at the time of service prior to the claim payment process.</p>
Same / Similar Specialty	A review performed by a board certified physician with a current, active, unrestricted license to practice medicine or a health professional in the same or similar specialty who typically treats the medical condition, performs the procedure or provides the treatment under review. <p>The <i>same specialty</i> refers to a practitioner with similar credentials and licensure as those who typically treat the condition or health problem in</p>

⁴ For these purposes, "coverage" means either the determination of (i) whether or not the particular service or treatment is a covered benefit pursuant to the terms of the particular member's benefit plan, or (ii) where a provider is required to comply with Aetna's patient management programs, whether or not the particular service or treatment is payable under the terms of the provider agreement.

	question in the appeal. A <i>similar specialty</i> refers to a practitioner who has experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems.
Uphold	To maintain the initial determination or subsequent appeal determination.
Urgent Care	A case involving medical or dental care or treatment where a delay in decision-making might seriously jeopardize the life or health of the member or jeopardize the member's ability to regain maximum function; or in the opinion of a healthcare professional with knowledge of the member's medical or dental condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal
Utilization Review	A formal evaluation (preservice, concurrent or postservice) of the medical necessity, efficiency or appropriateness of health care services and treatment plans.

Section III – Complaint Standards

A. Resolution Timeframes

Category	Timeframe
Expedited Complaints ⁵	5 calendar days
Standard Complaints	30 calendar days
Executive Complaints	30 calendar days or as outlined in the Executive, Legislative and Better Business Bureau Complaint Procedure
Regulatory Complaints	<ul style="list-style-type: none"> • Within the state or federal specific timeframe or the timeframe indicated by the requestor. • For follow up requests, resolve within the timeframe the regulator indicates or 10 calendar days. For urgent follow up issues, contact the requestor for TAT.

B. Case Processing

Complaints must be handled in accordance with the standards outlined in the Policy and Procedure related to:

1. Acknowledgement letters, if requested or required by state or federal law or regulation
2. Full and fair review (as described in "C" below)
3. Resolution time frames (as described in "A" above)
4. Resolution letter requirements (as described in "D" below)
5. Record of the complaint and its resolution
6. Offering of translation of complaint correspondence in the appropriate language following federal guidelines.

C. Full and Fair Review

⁵ Expedited complaints will be resolved sooner than stated if required due to a member's medical or dental condition.

Complaints must be handled in accordance with the Full and Fair Review standards outlined in the Policy and Procedure:

1. Accept complaints from a member or their authorized representative regardless of the length of time until the complaint submission.
2. Evaluate and coordinate investigations with the appropriate Aetna personnel, Subject Matter Experts (SME), as necessary including any aspects related to clinical care.
3. Allow extensions, as appropriate, when there is a delay in receiving requested information which is necessary for the resolution of the issue.

D. Resolution Letter Requirements

Resolution letters will be sent to the complainant or their authorized representative. The required letter components are as follows:

1. A statement of the reviewer's understanding of the complaint
2. Notification to the member of the disposition of the complaint
3. The right of appeal, where required by law or regulation or as applicable.
4. Content should be limited to the minimum necessary to provide a complete response while protecting the privacy of the individuals involved and meeting regulatory requirements.

Section IV – Appeal Standards

A. General

Levels of Appeal Standard

Aetna's standard is to offer a two-level appeal process for all Aetna plans except individual medical plans. Individual medical plans only receive one level of appeal for all types of appeals based on federal law. .

The below appeal process is superseded by any appeal process required by law or regulation, or as described in the governing Certificate of Coverage or Summary Plan Description.

Corporate Appeals Committee⁶

It is the responsibility of the Corporate Appeals Committee (CAC) to handle all second and/or final level appeals for medical necessity regarding any of the National Medical Excellence (NME) programs and to handle other second level appeals identified as appropriate by the Regional Medical Directors. The CAC will also handle final level appeals of benefit denials and benefit level reductions for NME issues when there is a clinical component to review. Refer to the Corporate Appeals Committee Policy and Procedure

B. Timeframes

The appeal resolution timeframes are shown below and are calculated from the date / time the appeal is received by Aetna or their designee.

Note: The timeframes noted below are not applicable for Federal Employees Health Benefit Plan [FEHBP]. Refer to the [FEHB Workflow](#) on the CG&A website for the FEHBP timeframes.

Standard Process (two levels)

⁶ Does not apply to Dental Products

Category	Level One	Level Two
Expedited Appeals ⁷	36 hours	36 hours
Pre-Service Appeals	15 calendar days	15 calendar days
Post-Service Appeals	30 calendar days	30 calendar days

Individual and One Level Process

Category	Level One
Expedited Appeals ⁷	72 hours
Pre-Service Appeals	30 calendar days
Post-Service Appeals	60 calendar days ⁸

C. Case Processing

Appeals must be handled in accordance with the following standards:

1. Timeframes to submit appeals
2. Acknowledgement notification as required by state or federal law or regulation or plan document
3. Full and fair review (as described in “D” below)
4. Case investigation / decision timeframes
5. Resolution letter timeframes
6. Resolution letter contents (as described in “E” below)
7. Record of the appeal and its resolution
8. Offering of translation of appeal correspondence in the appropriate language following Federal regulation.

D. Full and Fair Review

Appeals must be handled in accordance with the Full and Fair Review standards outlined in the Policy and Procedure:

1. Allow a member or a member’s authorized representative 180 calendar days to submit a level one appeal after receipt of the notification of an initial adverse determination.
2. Allow a member or a member’s authorized representative 60 calendar days to submit a level two appeal after receipt of the level one appeal resolution letter, when applicable.
3. Allow any active member to submit an appeal on behalf of their covered spouse or dependent child.
 - a. If the requestor does not meet the definition of an authorized representative process the appeal; however, provide a response only to the member who is the subject of the appeal.
4. Provide members or their authorized representatives the opportunity to submit written comments, documents records, and any other information relevant to the member’s appeal.
5. Take into account the substance of the appeal and all comments, documents, records and other information submitted by the appealing party without regard to whether such information was submitted or considered in the initial benefit determination.
6. Ensure that all documentation necessary to complete a review has been requested and taken into account including anything received after the appeal request but prior to resolution of the appeal.

⁷ Expedited appeals will be resolved sooner than stated if required due to a member’s medical condition.

7. Complete reviews that do not afford deference to the initial adverse benefit determination or subsequent adverse determination and that are conducted by individuals not involved in the initial determination process or subsequent adverse determinations – handling – prep, etc, or a subordinate of that person who rendered the initial determination or subsequent adverse determination.
8. Coordinate appropriate expertise of the appeal decision maker(s):
 - a. Coordinate case investigations with the appropriate Aetna Subject Matter Experts (SME) as necessary to assure issues are properly evaluated, including any aspects related to clinical care.
 - b. Consult with health care professionals (board certified as necessary) who have appropriate training and experience in the field of medicine (Same/Similar Specialty) for review of appeals of any adverse determination that is based in whole or in part on medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate. This consultation is performed during the final level of appeal (if there is only one level of appeal available, it would be done at that level, otherwise it is done at the second level of appeal), with the exception of Behavioral Health (which will continue to be performed during the first level of appeal).
 - c. Convene committee/panel reviews, as required by regulation or plan documents.
 - d. Allow extensions upon member request if they are unable to meet the panel review timeframe.
9. Expedite appeal investigations and resolution notices for urgent care, including urgent concurrent care and/or services.
10. Allow extensions, as allowed by federal regulations, when the appellant voluntarily agrees to the extension.
11. Continue coverage of previously approved services pending the outcome of the appeal.
12. On the final level of appeal, allow the appellant the opportunity to review any new information reviewed prior to making the final adverse determination.
13. Provide members or their authorized representatives, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the member's claim for benefits.
14. Appeal reviewers do not receive incentives for their reviews / decisions.
15. Notify the appellant of all appeal information in a culturally and linguistically appropriate manner as required by regulations.
16. Allow appellant to request an explanation in writing why Aetna determined that it met the criteria of strict adherence to the Affordable Care Act. Aetna will respond to that request within 10 days.

Committee Review

Aetna provides committee reviews for appeals when required by a state or federal law or regulation or when a committee review process is included in the governing certificate of coverage/summary plan description.

Committee Composition

The committee composition will be based on the state or federal mandate or requirement as outlined in the governing certificate of coverage/summary plan description. In the absence of such requirements, it will be comprised of a minimum of three plan representatives. If the determination, in whole or part, involves medical judgment, there will be at least one plan Medical Director.

Member Rights for Committee Review

During a committee review, a member is entitled to:

- Participate in the review
- Present their case in writing or directly to the committee
- Submit supporting material both before and during the review meeting
- Choose someone to assist them, this person may be an attorney

E. Resolution Letter Requirements

Resolution letters will be sent to the appealing party and the provider and the facility (when applicable). The required letter components are as follows:

- 1) Approvals (overturns)
 - a) A statement of the reviewer's understanding of the pertinent facts of the appeal (description of the health/dental care service/claim).
 - b) An explanation of the decision, including any instructions and/or payment information in easy-to-understand language that a layperson would understand and which does not include abbreviations or acronyms that are not defined or health care procedure codes that are not explained..

- 2) Denials (full and partial)
 - a) A statement of the reviewer's understanding of the pertinent facts raised / submitted by the appellant (description of the health or dental care service / claim).
 - b) Date of service, provider of service, amount of the claim and denial codes and their descriptions, when applicable to the case. Disclaimer that the ICD9/ICD10 or procedure code information is available upon request.
 - c) Evidence or documentation used for the basis of the decision.
 - d) The decision in clear terms in easy-to-understand language. including a complete explanation of the grounds for the denial written in plain language that a layperson would understand and which does not include abbreviations or acronyms that are not defined or health care procedure codes that are not explained.
 - e) A statement explaining the status of claims that are not eligible for reimbursement and have already been processed.
 - f) An explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the member's medical or dental circumstances in easy-to-understand language including a complete explanation of the grounds for the denial written in plain language that a layperson would understand and which does not include abbreviations or acronyms that are not defined or health care procedure codes that are not explained..
 - g) The specific rule, guideline, protocol or other similar criterion that was relied upon in making an adverse determination
 - h) A statement that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the member upon request.
 - i) The specific plan provisions on which an adverse benefit determination is based.
 - j) The body of the letter must include the information noted below. *Note: the signature line of the letter does not meet the intent of the requirement for titles and qualifications.*
 - k) For a benefit appeal, the title of each reviewer, OR
 - i) For medical necessity appeals, the title and qualifications of individuals who participated in the decision making process – including the specialty of each clinical reviewer
 - ii) Specifically state that the individual(s) participated in the appeal review and that specific names are available upon request.
 - l) A statement that the member is entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to the member's appeal.
 - m) A description of further appeal rights, if applicable, including time frames and how to file.
 - n) The following statement: "If you do not agree with the final determination on review, you have the right to bring a civil action under Section 502(a) of ERISA."
Note: This does not apply to plans that are not required to follow ERISA guidelines.
 - o) The availability of external review and how to request it, if applicable
 - i) include the right to obtain additional information related to external review.
 - ii) include a statement that the member is not responsible to bear cost of the external review.
 - p) Offer of assistance by the applicable State Ombudsman program following Federal regulation

- q) Content should be limited to the minimum necessary to provide a complete response while protecting the privacy of the individuals involved and meeting regulatory requirements.
- r) The following statement:
- i) Fully insured
 - (a) "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency."
 - ii) ASC (self insured)
 - (a) "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your Plan Administrator or your local U.S. Department of Labor Office."

Related Materials

Policies	<ul style="list-style-type: none"> • Corporate Appeals Committee Policy • External Review Policy • Privacy Complaints and Sanctions Policy • Provider Complaint and Appeal Policy • Records Retention and Management Policy • Review of Potential Quality of Care Concerns Policy • State-Specific External Review Policies • State-Specific Member Complaint and Appeal Policy Addenda
Procedures	<ul style="list-style-type: none"> • Corporate Appeals Committee Procedure • Dental Member Complaint Procedure • Dental Member Appeal Procedure • Member Appeal Procedure When the Plan Sponsor is the Claim Fiduciary • Member Complaint Procedure • Member Complaint and Appeal - Authorized Representative Procedure • Regulatory Complaint Procedure
Related Tools	<ul style="list-style-type: none"> • Addressing Appeal Resolution Letters Guidelines • Voiance Language Line • Certificates of Coverage (COC) Summary Plan Descriptions (SPD) or Summary of Coverage (SOC) • State Specific Member Appeal Processing Guide • Claim Fiduciary Chart • Documentation Guidelines • Federal Employees Health Benefit Program (FEHB) Workflow • Instructions for Identifying Plan Sponsor Claim Fiduciary Process • Lack of Information Workflow • Language Translation Workflow • Member Electronic Imaging Workflow • Plan Sponsor Tool • Receiving Calls from Members with Limited English Proficiency • Resolution Team Routing Guide • Request for Relevant Documents Workflow • Roles and Responsibilities Summary • Panel Hearing Workflow • Member Letter Selection Guides • NCM 505-01 Denial of Coverage

Approval to Implement:

Review Council/Policy Committee Signature Designee:

Signature on file

Date

Melissa Alexander

6/2/2015

Complaints, Grievances and Appeals

Posting Date: 06-10-2014

Subject Member Complaint and Appeal Policy Indiana Amendment	Originating Dept. Complaints, Grievances and Appeals Date: 06-10-2014
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Applies to: HMO-based EPO PPO MC/POS Medicare
 Type: New Revision Annual Review only; no changes

Related Communications:
 Aetna Member Complaint and Appeal Policy C.A. 001 and related procedures
 Medical Policy Administration - Member/Provider External Review Policy

Purpose:

This Amendment is written to meet statutory and legislative requirements specified in Indiana IC 27-8-28, IC 27-13-10, IC 27-8-17, IC 27-13-39 and IAC 760 Rule 59 that impact the Aetna Member Complaint and Appeal Policy pursuant to health plans licensed in the State of Indiana.

Background:

There are requirements in the State of Indiana that deviate from those detailed in Aetna Member Complaint and Appeal Policy, C.A. 001 (and related procedures). This amendment will be used in conjunction with C.A. 001 to comply with the State of Indiana’s statutory and legislative requirements.

Definitions:

Grievance: (760 IAC, Rule 59-3) and IC 27-8-28-6

- For a health maintenance organization and a limited service health maintenance organization, any dissatisfaction expressed by or on behalf of an enrollee of a health maintenance organization or a limited service health maintenance organization regarding the:
 - availability, delivery, appropriateness, or quality of health care services;
 - handling or payment of claims for health care services; or
 - matters pertaining to the contractual relationship between:
 - an enrollee and a health maintenance organization or a limited service health maintenance organization; or
 - (a group or individual contract holder and a health maintenance organization or a limited service health maintenance organization;

and for which the enrollee has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

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- For an insurer, any dissatisfaction expressed by or on behalf of a covered individual regarding:
 - a determination that a service or a proposed service is not appropriate or medically necessary;
 - a determination that a service or a proposed service is experimental or investigational;
 - the availability of participating providers;
 - the handling or payment of claims for health care services; or
 - matters pertaining to the contractual relationship between a:
 - covered individual and an insurer; or
 - group policyholder and an insurer; or
 - An insurer’s decision to rescind an accident and sickness insurance policy

and for which the covered individual has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of the dissatisfaction.

Utilization review means a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services provided or proposed to be provided to a covered individual. The term does not include the following:

- Elective requests for clarification of coverage, eligibility, or benefits verification.
- Medical claims review

Policy:

<p>IC 27-8-28-16 Policies and procedures for timely resolution of grievances</p>	<p>Aetna response:</p>
<p>Sec. 16. (a) An insurer shall establish written policies and procedures for the timely resolution of grievances filed under this chapter. The policies and procedures must include the following: (1) An acknowledgment of the grievance, given orally or in writing, to the covered individual within five (5) business days after receipt of the grievance.</p>	<p>For other than HMO, Aetna will acknowledge receipt of grievances (L1) in writing within 5 business days.</p>
<p>(c) A grievance must be resolved as expeditiously as possible, but not more than twenty (20) business days after the insurer receives all information reasonably necessary to complete the review.</p>	<p>For other than HMO, Aetna will resolve preservice grievances (L1) in writing within 15 calendar days, in accordance with DOL regulations. Postservice grievances (L1) will be resolved in writing within 20 business days.</p>
<p>IC 27-8-28-17 Policies and procedures for timely resolution of appeals of grievance</p>	

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decisions; filing of report for violation	
<p>Sec. 17. (a) An insurer shall establish written policies and procedures for the timely resolution of appeals of grievance decisions. The procedures for registering and responding to oral and written appeals of grievance decisions must include the following: (1) Written or oral acknowledgment of the appeal not more than five (5) business days after the appeal is filed.</p>	<p>For other than HMO, Aetna will acknowledge receipt of appeals (L2) in writing within 5 business days.</p>
<p>(b) In the case of an appeal of a grievance decision described in section 6(1) or 6(2) of this chapter, an insurer shall appoint a panel of one (1) or more qualified individuals to resolve an appeal. The panel must include one (1) or more individuals who: (1) have knowledge of the medical condition, procedure, or treatment at issue; (2) are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the health care procedure, treatment, or service; (3) are not involved in the matter giving rise to the appeal or in the initial investigation of the grievance; and (4) do not have a direct business relationship with the covered individual or the health care provider who previously recommended the health care procedure, treatment, or service giving rise to the grievance.</p>	<p>For other than HMO, Aetna will offer a hearing panel for appeals concerning medical necessity or experimental/investigational denials. The panel will be comprised of individuals as prescribed and the member will be invited to participate.</p>
<p>(c) An appeal of a grievance decision must be resolved: (1) as expeditiously as possible, reflecting the clinical urgency of the situation; and (2) not later than forty-five (45) days after the appeal is filed.</p>	<p>For other than HMO, Aetna will resolve preservice appeals (L2) in writing within 15 calendar days and Post Service appeals 30 calendar days, in accordance with DOL regulations.</p>
<p>IC 27-13-10-7 Resolution of grievances</p>	
<p>Sec. 7. (a) A health maintenance organization shall establish written policies and procedures for the timely resolution of grievances filed under this chapter. The policies and procedures must include the following: (1) An acknowledgment of the grievance, orally or in writing, to the enrollee or subscriber within three (3) business days.</p>	<p>For HMO, Aetna will acknowledge receipt of grievances (L1) in writing within 3 business days.</p>

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<p>(c) A grievance must be resolved as expeditiously as possible, but not more than twenty (20) business days after the grievance is filed.</p>	<p>For HMO, Aetna will resolve preservice grievances (L1) in writing within 15 calendar days, in accordance with DOL regulations. Postservice grievances (L1) will be resolved in writing within 20 business days.</p>
<p>(d) A health maintenance organization shall notify the enrollee or subscriber in writing of the resolution of the grievance within five (5) business days after completing the investigation. The grievance notice must contain the following...</p> <p style="padding-left: 40px;">(4) The department, address, phone number through which an enrollee may contact a qualified representative to obtain more information about the decision or the right to appeal.</p>	<p>Aetna will notify the enrollee, subscriber or their authorized representative in writing as soon as possible after resolution of the appeal but no later than the required due date of the case (as dictated by Aetna Policy) or within five (5) business days after completion of the investigation, whichever is sooner.</p> <p>The resolution letters will include a department name, address and telephone number to contact for additional information about the decision or the right to appeal.</p>
<p>IC 27-13-10-8 Appeals of grievance decisions; filing of report for violation</p>	
<p>Sec. 8. (a) A health maintenance organization shall establish written policies and procedures for the timely resolution of appeals of grievance decisions. The procedures for registering and responding to oral and written appeals of grievance decisions must include the following: (1) Acknowledgment of the appeal, orally or in writing, within three (3) business days after receipt of the appeal being filed.</p>	<p>For HMO, Aetna will acknowledge receipt of appeals (L2) in writing within 3 business days.</p>
<p>(b) The health maintenance organization shall appoint a panel of qualified individuals to resolve an appeal. An individual may not be appointed to the panel who has been involved in the matter giving rise to the complaint or in the initial investigation of the complaint. Except for grievances that have previously been appealed under IC 27-8-17, in the case of an appeal from the proposal, refusal, or delivery of a health care procedure, treatment, or service, the health maintenance organization shall appoint one (1) or more individuals to the panel to resolve the appeal. The panel must</p>	<p>For HMO, Aetna will offer a hearing panel for appeals. The panel will be comprised of individuals as prescribed and the member will be invited to participate.</p>

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<p>include one (1) or more individuals who: (1) have knowledge in the medical condition, procedure, or treatment at issue; (2) are in the same licensed profession as the provider who proposed, refused, or delivered the health care procedure, treatment, or service; (3) are not involved in the matter giving rise to the appeal or the previous grievance process; and (4) do not have a direct business relationship with the enrollee or the health care provider who previously recommended the health care procedure, treatment, or service giving rise to the grievance.</p>	
<p>(c) An appeal of a grievance decision must be resolved as expeditiously as possible and with regard to the clinical urgency of the appeal. However, an appeal must be resolved not later than forty-five (45) days after the appeal is filed.</p>	<p>For HMO, Aetna will resolve preservice appeals (L2) in writing within 15 calendar days and Post Service appeals 30 calendar days, in accordance with DOL regulations.</p>
<p>(f) A health maintenance organization shall notify the enrollee or subscriber in writing of the resolution of the appeal of the grievance within five (5) business days after completing the investigation. The grievance notice must contain the following...</p> <p>(4) The department, address, phone number through which an enrollee may contact a qualified representative to obtain more information about the decision or the right to appeal.</p>	<p>Aetna will notify the enrollee, subscriber or their authorized representative in writing as soon as possible after resolution of the appeal but no later than the required due date of the case (as dictated by Aetna Policy) or within five (5) business days after completion of the investigation, whichever is sooner.</p> <p>The resolution letters will include a department name, address and telephone number to contact for additional information about the decision or the right to appeal.</p>
<p>State Holiday</p>	<ul style="list-style-type: none"> • New Year's Day • Martin Luther King, Jr. • Good Friday • Primary Election Day Tuesday • Memorial Day • Independence Day • Labor Day

**Complaints, Grievances
and Appeals**

Posting Date: 06-10-2014

	<ul style="list-style-type: none">• Columbus Day• General Election Day• Veterans' Day• Thanksgiving Day• Lincoln's Birthday• Washington's Birthday• Christmas Day and observed day
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Exception Process: There are no exceptions to this amendment.

FOR FURTHER INFORMATION:

Contact Name: **Melissa Alexander**

Dept./Unit: **National Complaints, Grievances and Appeals**

Phone: **904-351-63247**

Indiana National External Review Policy Addendum

Responsible Department: National External Review Unit	Approved by: Andrew Baskin, M.D. Signed original on file in CMO
	Signature Authority: Sharon Saravia

Legislation Information

Bill/Regulation/Bulletin:	House Bill 1309, Senate Bill 365, and effective 9/23/10; 2011-IN-003_SB 461	Effective Date:	01/01/1999
Jurisdiction:	Applies contract state.	Revision Date:	03/31/2016
		Annual Review Date:	03/2017

Applicability

<p>Medical Plans</p> <input checked="" type="checkbox"/> Group <input checked="" type="checkbox"/> Blanket <input checked="" type="checkbox"/> Individual <input checked="" type="checkbox"/> Conversion	<p>Medical Plans</p> <input checked="" type="checkbox"/> Traditional Fee for Service <input checked="" type="checkbox"/> Student Health <input checked="" type="checkbox"/> Indemnity <input checked="" type="checkbox"/> Medicare Supplement <input checked="" type="checkbox"/> PPO <input checked="" type="checkbox"/> Pharmacy Benefits <input checked="" type="checkbox"/> POS <input checked="" type="checkbox"/> Stand Alone Dental <input checked="" type="checkbox"/> HMO <input checked="" type="checkbox"/> Long Term Care <input checked="" type="checkbox"/> Fixed Indemnity <input checked="" type="checkbox"/> Stand Alone Vision	<p>Life and Disability Products</p> <input checked="" type="checkbox"/> Disability Income AD&D <p>Other</p> <input checked="" type="checkbox"/> Fully Insured <input checked="" type="checkbox"/> Association Plans <input checked="" type="checkbox"/> Multiple Employer Trust Plans
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Related Policies: Aetna National External Review Policy and Member Complaint and Appeal Policy

Purpose

This addendum is written to meet all regulatory and legislative requirements specified in 1999 House Bill 1309 and Senate Bill 365, effective 9/23/10; 2011-IN-003_SB 461, Implementing dependant age and external review requirements in compliance with the Federal Patient Protection and Affordable Care Act affecting the external review policy pursuant to managed health plans licensed in the State of Indiana.

Aetna has developed this addendum to the External Review policy to meet legal, regulatory and accreditation standard requirements for Indiana members.

Indiana National External Review Policy Addendum

Policy

The policy points addressed below modify the External Review policy to comply with Indiana State law regulating all fully insured Managed Health Plans.

State Specific ERO Process

IC 27-8-28-6

"Grievance" means any dissatisfaction expressed by or on behalf of a covered individual regarding:

- (1) a determination that a service or proposed service is not appropriate or medically necessary;
- (2) a determination that a service or proposed service is experimental or investigational;
- (3) the availability of participating providers;
- (4) the handling or payment of claims for health care services; or
- (5) matters pertaining to the contractual relationship between:
 - (A) a covered individual and an insurer; or
 - (B) a group policyholder and an insurer; or
- (6) an insurer's decision to rescind an accident and sickness insurance policy; and for which the covered individual has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

IC 27-8-29-12

Insurer to establish external grievance procedures

A health maintenance organization shall establish and maintain an external grievance procedure for the resolution of grievances regarding:

- (1) The following determinations made by the insurer or an agent of the insurer regarding a service proposed by the treating health care provider:
 - A. An adverse determination of appropriateness.
 - B. An adverse determination of medical necessity.
 - C. A determination that a proposed service is experimental or investigational.
 - D. A denial of coverage based on a waiver described in IC 27-8-5-2.5(e) (expired July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1, 2007, and repealed).
- (2) The insurer's decision to rescind an accident and sickness insurance policy.

IC 27-8-29-13

Requirements for external grievance procedure; independent

- (1) allow a covered individual, or a covered individual's representative, to file a written request with the insurer for an external grievance review of the insurer's
 - (A) appeal resolution under IC 27-8-28-17 or
 - (B) denial of coverage based on a waiver described in IC 27-8-5-2.5(e) (expired July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1, 2007, and repealed);

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- (2) not more than one hundred **twenty (120) days** after the covered individual is notified of the resolution; and
- (3) provide for:
 - (A) an expedited external grievance review for a grievance related to an illness, a disease, a condition, an injury, or a disability if the time frame for a standard review would seriously jeopardize the covered individual's:
 - (i) life or health; or
 - (ii) ability to reach and maintain maximum function; or
 - (B) a standard external grievance review for a grievance not described above

Ind. Code § 27-8-28-13(2) Does not require exhaustion of the internal appeals before filing ERO

When a request is filed, the insurer shall:

- (1) Select a different independent review organization for each external grievance from the list of department certified independent review organizations; and
- (2) Rotate the choice of an independent review organization among all certified independent review organizations before repeating a selection.

The independent review organization chosen shall assign a medical review professional who is board certified in the applicable specialty for resolution of an external grievance.

The independent review organization and the medical review professional conducting the external review under may not have a material professional, familial, financial, or other affiliation with any of the following:

- (1) The insurer.
- (2) Any officer, director, or management employee of the insurer.
- (3) The health care provider or the health care provider's medical group that is proposing the service.
- (4) The facility at which the service would be provided.
- (5) The development or manufacture of the principal drug, device, procedure, or other therapy that is proposed for use by the treating health care provider.

However, the medical review professional may have an affiliation under which the medical review professional provides health care services to covered individuals of the insurer and may have an affiliation that is limited to staff privileges at the health facility, if the affiliation is disclosed to the covered individual and the insurer before commencing the review and neither the covered individual nor the insurer objects.

A covered individual shall not pay any of the costs associated with the services of an independent review organization under this chapter. All costs must be paid by the insurer.

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IC 27-8-29-14

Rights of individuals who file grievances

- (a) A covered individual who files an external grievance under this chapter:
- (1) shall not be subject to retaliation for exercising the covered individual's right to an external grievance under this chapter;
 - (2) shall be permitted to utilize the assistance of other individuals, including health care providers, attorneys, friends, and family members throughout the review process;
 - (3) shall be permitted to submit additional information relating to the proposed service throughout the review process; and
 - (4) shall cooperate with the independent review organization by:
 - (A) providing any requested medical information; or
 - (B) authorizing the release of necessary medical information.

An insurer shall cooperate with an independent review organization by promptly providing any information requested by the independent review organization.

IC 27-8-29-15

Independent review organizations; determinations

An independent review organization must make a determination to uphold or reverse the insurer's appeal resolution within **72 hours** for an expedited external grievance filed, and within 15 business days after the appeal is filed for a standard appeal.

When making the determination, the independent review organization shall apply:

- (1) standards of decision making that are based on objective clinical evidence; and
- (2) the terms of the covered individual's accident and sickness insurance policy.

The independent review organization shall notify the insurer and the covered individual of the determination made:

- (1) for an expedited external grievance, **within seventy-two (72) hours** after making the determination; and
- (2) for a standard external grievance filed, **within fifth teen (15) business days** hours after making the determination.

IC 27-8-29-16

Binding determinations

The determination of the IRO is binding on the insurer.

IC 27-8-29-17

Reconsideration of resolution by insurer

If, at any time during an external review performed, the covered individual submits information to the insurer that is relevant to the insurer's resolution of the covered individual's appeal of a grievance decision and that was not considered by the insurer:

- (1) the insurer may reconsider the resolution; and

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- (2) if the insurer chooses to reconsider, the independent review organization shall cease the external review process until the reconsideration is completed.

An insurer reconsidering the resolution of an appeal of a grievance decision due to the submission of information shall reconsider the resolution based on the information and notify the covered individual of the insurer's decision:

- (1) 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 covered individual's:
 - a. life or health; or
 - b. ability to reach and maintain maximum function; or
- (2) within fifteen (15) days after the information is submitted, for a reconsideration not described in above.

If the decision reached is adverse to the covered individual, the covered individual may request that the independent review organization resume the external review under this chapter.

If an insurer to which information is submitted chooses not to reconsider the insurer's resolution under, the insurer shall forward the submitted information to the independent review organization not more than two (2) business days after the insurer's receipt of the information.

The external review process does not affect the terms of coverage included in a policy, certificate, or contract under which a covered individual receives health care benefits.

If a covered individual has the right to an external review of a grievance under Medicare, the covered individual may not request an external review of the same grievance under this chapter. The following organizations have been certified as IROs in Indiana.

IC 27-13-10.1-8 IS

The department shall establish and maintain a process for annual certification of independent review organizations.

- a. The department shall certify a number of independent review organizations determined by the department to be sufficient to fulfill the purposes of this chapter.
- b. An independent review organization shall meet the following minimum requirements for certification by the department:
 - (1) Medical review professionals assigned by the independent review organization to perform external grievance reviews under this chapter:
 - (A) must be board certified in the specialty in which an enrollee's proposed service would be provided;
 - (B) must be knowledgeable about a proposed service through actual clinical experience;
 - (C) must hold an unlimited license to practice in a state of the United States; and

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- (D) must have no history of disciplinary actions or sanctions including:
 - (i) loss of staff privileges; or
 - (ii) restriction on participation; taken or pending by any hospital, government, or regulatory body.
- (2) The independent review organization must have a quality assurance mechanism to ensure the:
 - (A) timeliness and quality of reviews;
 - (B) qualifications and independence of medical review professionals;
 - (C) confidentiality of medical records and other review materials; and
 - (D) satisfaction of enrollees with the procedures utilized by the independent review organization, including the use of enrollee satisfaction surveys.
- (3) The independent review organization must file with the department the following information before March 1 of each year:
 - (A) The number and percentage of determinations made in favor of enrollees.
 - (B) The number and percentage of determinations made in favor of health maintenance organizations.
 - (C) The average time to process a determination.
 - (D) The number of external grievance reviews terminated due to reconsideration of the health maintenance organization before a determination was made.
 - (E) Any other information required by the department.

The information required under this subdivision must be specified for each health maintenance organization for which the independent review organization performed reviews during the reporting year.

- (4) The independent review organization must retain all records related to an external grievance review for at least three (3) years after a determination is made under section 4 of this chapter.
 - (5) Any additional requirements established by the department.
- c. The department may not certify an independent review organization that is one (1) of the following:
 - (1) A professional or trade association of health care providers or a subsidiary or an affiliate of a professional or trade association of health care providers.
 - (2) A health insurer, health maintenance organization, or health plan association or a subsidiary or an affiliate of a health insurer, health maintenance organization, or health plan association.
 - d. The department may suspend or revoke an independent review organization's certification if the department finds that the independent review organization is not in substantial compliance with the certification requirements under this section.
 - e. The department shall make available to health maintenance organizations a list of all certified independent review organizations.

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- f. The department shall make the information provided to the department under subsection (c)(3) available to the public in a format that does not identify individual enrollees.

IC 27-8-29-21

Filing description of grievance procedure

An insurer shall each year file with the commissioner a description of the grievance procedure established by the insurer under this chapter, including:

- (1) the total number of external grievances handled through the procedure during the preceding calendar year;
- (2) a compilation of the causes underlying those grievances; and
- (3) a summary of the final disposition of those grievances;
- (4) for each independent review organization used by the insurer during the reporting year.

The information required must be filed with the commissioner on or before March 1 of each year. The commissioner shall:

- (1) make the information required to be filed available to the public; and
- (2) prepare an annual compilation of the data required that allows for comparative analysis.

The commissioner may require any additional reports that are necessary and appropriate for the commissioner to carry out the commissioner's duties under this article.

The state will notify the health plan of any additions or deletions to this list during the list effective time or you may refer to www.in.gov/idoi/2690.htm for additions and deletions to this list during the list effective time. The list was last updated on 11/201. This list will be used to assign cases on an equal and rotating basis by the External Review Unit.

List of Licensed Independent Review Organizations

IRO Name/Address	Contact Numbers	Contact Person	License Number
Advanced Medical Reviews, Inc. 10780 Santa Monica Blvd, Ste 333 Los Angeles, CA 90025	(310) 575-0900 (310) 470-0127 fax	Thomas Sandifer StateReg@admere.com	606909
Health Care Excel, Inc. 2901 Ohio Blvd, Ste 112 Terre Haute, IN 47803	(812) 234-1499 (317) 347-4567 fax	Betsy Jerome bjerome@hce.org	729728
H.H.C. Group 438 N. Frederick Ave, Ste 200A Gaithersburg, MD 20877	(301) 963-0762 ext 146 (301) 963-9431 fax	Clare Liedquist c_liedquist@hhcgroup.com	547501
IMX Medical Management Services, Inc. Two Bala Plaza, Ste 600 Bala Cynwyd, PA 19004	(610) 667-4463 (610) 667-4764 fax	Darcy Saunders darcy.saunders@imxmed.com	693443
Independent Medical Expert Consulting Services, Inc. (IMEDECS) 157 S. Broad St.	(215) 855-4633 (215) 855-5318 fax	Jackie Kneeland jkneeland@imedecs.com	614735

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Lansdale, PA 19446			
MAXIMUS, Inc. 50 Square Dr, Ste 210 Victor, NY 14564	(703) 251-8545 (585) 425-5296 fax	Thomas Naughton thomasnaughton@maximus.com	611741
MCMC, LLC 300 Crown Colony Dr, Ste 203 Quincy, MA 02169	(617) 375-7700 (877) 879-3089 fax	Nichole Lewis nicole.lewis@mcmcllc.com	609701
MedHealth Review, Inc. 661 E. Main St, Ste 200-305 Midlothian, TX 76065	(972) 921-9094 (972) 775-6056 fax	Robert Wright medhealthreview@aol.com	660906
Medical Consultants Network (MCN) 901 Boren Ave, Ste 1400 Seattle, WA 98104	(206) 343-6100 ext 2206 (206) 623-4956	Erik Halse ehalse@mcn.com	736605
Medical Review Institute of America, Inc. 2875 S. Decker Lake Dr, Ste 550 Salt Lake City, UT 84119	(800) 654-2422 (801) 261-3189 fax	Aja Ogzewalla aja.ogzewalla@mrtoa.com	712948
Medwork of Wisconsin 5840 Arndt Road, Ste 2 Eau Claire, WI 54701	(800) 426-1551 (715) 552-0748	Melissa Wall independent.review@medworkiro.com	775639
National Medical Reviews 260 Knowles Ave, Ste 330 Southampton, PA 18966	(215) 352-7800 (215) 352-7801 fax	Mr. Meredith Merlini mmerlini@nrmusa.com	554821
Permedion, Inc. 350 Worthington Rd, Ste H Westerville, OH 43082	(614) 895-9900 (614) 895-6784 fax	Thomas Schultz tschultz@hms.com	611210
Prest & Associates, Inc. 2712 Marshall Court, Ste #1 Madison, WI 53705	(608) 232-9919 (608) 232-9929 fax	Judith C. Shaffer jshaffer@prestmds.com	681784
Specialty Independent Review Organization, Inc. (SIRO) 445 FM 1382, Ste 3344 Cedar Hill, TX 75104	(972) 775-1411 (972) 775-8035 fax	Wendy Perelli specialtyIRO@aol.com	520713
The Dyll Review 25 Highland Park Village #100-177 Dallas, TX 75205	(888) 950-4333 (888) 950-4443 fax	Frank Rusch frusch@gmail.com	730637
VHQC 9830 Mayland Dr, Ste J Henrico, VA 23233	(804) 287-0289 (804) 287-0298 fax	Jaime Walker jwalker@vhqc.org	519584

This Addendum is to be used in conjunction with the External Review policy and state specific legislation

Indiana National External Review Policy Addendum

ERO Director Signature/Date

FOR FURTHER INFORMATION:

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Dept./Unit: External Review Unit
Conveyor: **F350**

To make changes in distribution, please contact Deborah Rudolph, Complaint & Appeal Program Mgr –
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