

Grievance Process - Indiana  
Implemented: 04/30/04

## **Topics**

### Definitions

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#### Grievance Extensions

#### Pend Guidelines After Extension is Requested

#### Overtured Autism Spectrum Disorder (Applied Behavioral Analysis Treatment) Services

### **Definitions**

All grievances with the issue state of Indiana are a two-step process.

Indiana has a First Level and Second Level Grievance available. You will need to follow your normal First Level Grievance and Second Level Grievance workflows.

We have 20 business (28 calendar) days to resolve the grievance.

If a 10 business (14 calendar) day extension is requested, request a 24 hour rush review for all referrals associated with the first or second level grievance.

A covered individual or their authorized representative may file a grievance orally or in writing.

An acknowledgement letter must be sent within five business days of receipt of all grievance requests.

### **First and Second Level Grievances**

Decisions to covered persons, authorized persons and providers must be communicated within 20 business (28 calendar) days of receipt of the grievance. If unable to make a decision within the 20 business (28 calendar) day period due to circumstances beyond our control, the time period may be extended by an additional 10 business (14 calendar) days if the insurer provides written notification of the following to the insured or insured's authorized representative:

- Notify the covered individual in writing of the reason for the delay before the 20th business (28th calendar) day; and
- Issue a written decision regarding the grievance within an additional 10 business (14 calendar) days.

For Second Level Grievances, the insured has the right to attend the Grievance Panel in person or by teleconference regarding appeals or pre-determinations only for decisions related to:

- A determination that a service or proposed service is either not appropriate or medically necessary.
- A determination that a service or proposed service is experimental or investigational.

## Grievance Extensions

### Group Market Plans

We have 20 business (28 calendar) days to resolve a grievance.

The grievance extension does **not** apply to reviews related to the benefit determination for group market plans.

Group market plans will follow the Department of Labor Claims Regulation when requesting information from external sources.

**Note:** If all information needed to make a determination has been requested from an external source, but has not been received by the 45th calendar day from the date the request was received in the company, follow normal suspend guidelines.

### IM/SP Plans

We have 20 business (28 calendar) days to resolve a grievance.

If the grievance is unable to be resolved within 20 business (28 calendar) days, the time period may be extended by 10 business (14 calendar) days if the insurer provides written notification of the following to the insured or the insured's authorized representative:

- Insurer has not resolved the grievance.
- The reason additional time is needed.

If it is the 26<sup>th</sup> day from the date the correspondence was received within the company...

And...	Then...
all information needed to make a determination is in-house, but there isn't enough time to have the grievance reviewed by the 20th business (28th calendar) day	request a 10 business (14 calendar) day extension.
requested external information needed to complete the review has <b>not</b> been received	follow normal suspend guidelines.

Customer resolution specialists must complete a free-form letter and insert the following statement. If you have access to the Correspondence glossary, the following insert is located in the Grievance/Extension folder of the glossary as Extension:

"We are in the process of reviewing this request but need additional time to complete our review [Why]. Therefore, we are requesting an extension of [Number] calendar days until [Date]. Once we complete our review, we will promptly advise [Who] of our determination. We appreciate your patience during this process."

**Note:** The WHY field must contain an explanation of why the extension is necessary.

**Examples:**

- Since we received additional medical records from Dr. Smith.
- Since we need additional time to review George Washington's agent statement.
- Since additional review is necessary.

**Pend Guidelines After Extension is Requested**

If an extension is requested, the pend guideline for all referrals immediately moves to 24 hours. Follow these referral guidelines:

- Key **IN Appeal, return within 24 hours** in the e-mail SUBJECT line for all referrals and e-mails regarding the COR document.
- Flag the e-mail as high priority.
- Notify your supervisor immediately if you don't receive a response from the referring area within the 24 hour pend guideline.

**Note:** For HM referrals, add the name of the grievance coordinator to the SUBJECT line and CC. If you get an out of office auto reply, forward the high priority e-mail.

If a determination is made outside of 20 business (30 calendar) days, document the reason in the comment section of the A&G log (e.g., "Health Management had the referral for 1 week.").

### **Overtured Autism Spectrum Disorder (Applied Behavioral Analysis Treatment) Services**

During the appeal process, if there are services related to applied behavioral analysis treatment provided for autism spectrum disorder that are overturned, the overturned services must be sent for reprocessing as soon as the overturn decision is made. If other services are still under review, we cannot wait until the end of the review of the other services to reprocess the overturned services.

## **Health Management**

### **State Regulatory Requirements**

**State of: Indiana**

## **Appeals Process and Independent Review - Indiana**

### **Statement**

Assurant Health Management will comply with Indiana legislation by adding the State requirements for Utilization Review/Appeals and Independent External Review to our internal process.

### **Requirements**

#### **General Process Standards**

1. Assurant Health provides the patient, provider or facility rendering service the opportunity to submit written comments, documents, records and other information relating to the case being appealed.
2. All appeal information will be documented on the appropriate medical management system/database and be kept confidential per Assurant Health policy. The system/database documentation will include the name of the insured (patient), provider, and/or facility, dates of appeal reviews, documentation of actions taken and final resolution. Hard copies of all correspondence from the patient, provider, or facility or Assurant Health will be maintained in locked filing cabinets and imaged after six months of no activity.
3. An insured will not be penalized for filing an appeal.
4. Appeals considerations will take into account all documents, records and other information submitted by the insured, provider or facility relating to the case whether or not the information was submitted for the initial consideration of the case.

#### **Level I Appeal (Standard)**

1. Level I Appeal is initiated upon request, in writing, by Fax or by telephone, from the patient, enrollee, attending physician, other ordering provider or the facility rendering service following non-certifications issued during prospective, concurrent and retrospective reviews.
2. The insured, provider or facility rendering services will be allowed 180 calendar days after the receipt of a notice of non-certification to initiate the appeal process.
3. An acknowledgement letter will be sent to the requestor within 5 business days of receipt of the appeal request.
4. A statement from the attending physician or other ordering provider is required to complete the Level I Appeal process.
5. Requests for additional documentation from the treating provider will include a signed consent from the insured/claimant.
6. The treating provider will be contacted by phone if any additional documentation is required. If the requested documentation is not received by fax within two (2) business days, the review will proceed with the information provided for the initial review and any additional information submitted with the appeal request.

## **Health Management**

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#### **Appeals Process and Independent Review - Indiana**

7. The appeal will be reviewed by a specialty matched clinical peer reviewer, who is Board Certified by the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists. The reviewer will be familiar with the principles and procedures of utilization management.
8. The appeal review will not be conducted by the peer reviewer who issued the initial adverse decision. All available information will be included with the appeal.
9. Insureds, providers and facilities will be notified in writing regarding the outcome of the decision, within twenty (20) business days of initiation of the appeal process.
10. The appeal response letter upholding an adverse decision will include:
  - The principal reason for the decision;
  - The process for requesting an additional appeal;
  - Screening criteria used;
  - A list of records used for the review; and
  - Insured's Right to Appeal – Indiana enclosure.

#### **Level II Appeal Panel Review**

1. A Level II Appeal Panel Review will be offered with all Level I Appeal non-certification decisions.
2. A Level II Appeal request must be received in writing from the insured, physician or designated representative within sixty (60) business days of the date of the Level I Appeal determination letter.
3. An acknowledgement letter will be sent to the requestor within five (5) business days of receipt of the appeal request.
4. The insured has the right to appear in person or, if unable to appear, otherwise appropriately communicate with the appeal panel.
5. A Level II Appeal determination will be rendered by the Appeal Panel within forty-five (45) days of receipt of all required information.
6. The insured and appealing party, insured, provider and facility will be notified, in writing of the Appeal Panel's decision, within five (5) business days of issuing the decision.
7. A Level II notification letter will include:
  - The principal reason for the decision;
  - Screening criteria used; and
  - Insured's Right to Appeal – Indiana enclosure

## Health Management

### State Regulatory Requirements

State of: Indiana

## Appeals Process and Independent Review - Indiana

### Independent External Review

1. The insured or his designated representative may request an independent review if:
  - An adverse decision of appropriateness or medical necessity was rendered; OR
  - A proposed service was determined to be experimental/investigational; AND
  - The internal appeal process has been exhausted; AND
  - A previous independent review was not completed.
2. The insured or designated representative may request an expedited Independent Review if the time frame for a standard review would seriously jeopardize the insured's life or health or ability to reach and maintain maximum function.
3. The insured or designated representative must:
  - Submit a written request to Assurant Health within 120 days of receipt of the upheld Level II Appeal decision.
  - Provide any requested medical information; and
  - Authorize the release of necessary medical information.
4. Upon receipt of a request for external review, Assurant Health will:
  - select an Independent Review Organization ("IRO") on a rotating basis from the list of Independent External Review Entities certified by the commissioner; no insurer will select the same IRO until they have completed the whole list;
  - Promptly provide any information requested by the IRO;
  - Pay the IRO charges.
5. The insured will:
  - Not be penalized for requesting an Independent Review;
  - Be permitted to seek assistance from an individual of their choice; and
  - Be allowed to submit additional information relating to the service throughout the review process
6. The IRO will:
  - Make a determination to uphold or reverse the Level II decision based on information gathered from the insured or the insured's designated representative, Assurant Health, the treating health care provider, and any additional information that the IRO considers necessary and appropriate:
    - Within seventy-two (72) hours after the appeal is filed for an expedited external appeal; or
    - Within fifteen (15) business days after the appeal is filed for a standard external appeal.

## Health Management

### State Regulatory Requirements

State of: Indiana

#### Appeals Process and Independent Review - Indiana

- Notify the insured or designated representative and Assurant Health of the decision within seventy-two (72) hours of making a decision and within twenty-four (24) hours for an expedited review;
  - Cease the external review process if the insured or designated representative submits information to Assurant Health that is relevant to the internal determination and was not previously considered and Assurant Health chooses to reconsider based on that information.
    - If new information is received, it shall be reviewed by a physician to determine if it impacts Assurant Health's position. The physician shall inform the appeal coordinator whether a reconsideration will take place.
    - Reconsideration must be completed by Assurant Health within seventy-two (72) hours when related to an illness, disease, condition, injury, or disability that would seriously jeopardize the insured's life, health or ability to reach and maintain maximum function or within fifteen (15) days for all other circumstances.
    - If a reconsideration results in an adverse decision, the insured may request that the IRO resume the external review.
    - If Assurant Health chooses not to reconsider, Assurant Health shall forward the submitted information to the IRO within two (2) business days after receipt of the information.
7. Upon request from the insured, the IRO will provide all information reasonably necessary for the insured to understand the
- Effect of the determination on the insured; and
  - Manner in which Assurant Health may be expected to respond to the determination.
8. The IRO's decision is binding on Assurant Health. However, the insured is entitled to any other remedies as allowed by law.
9. The insured or designated representative may not file more than one external grievance of Assurant Health's appeal resolution.
10. All costs associated with the independent external review will be paid by Assurant Health.

#### Annual reports

Annual Appeal and Independent Review reports will be submitted by March 1 in a format prescribed by the commissioner.

#### Key Definitions

*Covered individual* means an individual who is covered under an accident and sickness insurance policy.

## Health Management

### State Regulatory Requirements

State of: Indiana

#### Appeals Process and Independent Review - Indiana

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

- (1) a determination that a proposed service is not appropriate or medically necessary;
- (2) a determination that a 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; 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.

*Grievance procedure* means a written procedure established and maintained by an insurer for filing, investigating, and resolving grievances and appeals.

*Insurer* means any person who delivers or issues for delivery an accident and sickness insurance policy or certificate in Indiana.

Version # 8

Assurant Health: Time Insurance Company, Union Security Insurance Company, John Alden Life Insurance Company

**Assurant Health**  
**Insured's Right To Appeal - Indiana**

You have the right to appeal the adverse decision or you may designate a representative to appeal for you. The following information describes the appeal procedure.

**Level I Appeal Request**

We allow you, your provider, or facility rendering services 180 calendar days after the receipt of the adverse decision to request a Level I appeal.

- Include in your request any additional medical information that you feel is pertinent to your case. \*\*
- We will send you written acknowledgement of your request.
- The Level I Appeal review will be completed and written notification of the decision will be sent to you within twenty (20) business days of initiation of the appeal process.
- Send the request either in writing or by telephone or fax to:

Assurant Health  
Health Management - Appeals Department  
PO Box 3264  
Milwaukee, WI. 53201-3264

Telephone: 800-454-5105, ext. 6239  
Fax: 414-299-7555 Attn: Health Management Appeals Department

**Level II Appeal Request**

If you wish to appeal the Level I Appeal decision, you or your designated representative may request a Level II Appeal Panel review. This request must be received in writing at the above address within sixty (60) business days of the date of the Level I Appeal decision letter.

- Include in your request any additional medical information that you feel is pertinent to your case. \*\*
- We will send you written acknowledgement of your request.
- You have the right to attend the Level II Appeal Panel meeting. We will notify you of the date and time prior to the meeting.
- The Level II Appeal Panel review will be completed within forty-five (45) days after the appeal is filed. We will notify you of the decision.
- Our internal appeals process will be exhausted upon completion of the Level II Appeal Panel decision.

*\*\*No genetic information, including family history should be provided. We do not use or collect genetic information for underwriting purposes. We may; however, request or require a genetic test or family history in order to make a determination regarding payment when the medical necessity or appropriateness of an item or service depends on your genetic makeup.*

### **Independent External Review Request**

If you are dissatisfied with the Level II Appeal Panel decision, you have the right to file a request for an Independent External Review if the following criteria are met:

- An adverse decision of appropriateness or medical necessity was rendered or a proposed service was determined to be experimental/investigational or cosmetic; and
- You have completed the internal appeal process; and
- The adverse decision has NOT been previously reviewed by an Independent External Review Entity.

If you wish to have an Independent External Review, you or your designated representative will need to send a written request to us at the above listed address within 120 days of receiving the Level II Appeal Panel decision. Please include your authorization to release medical information needed for this review.

We will select an Independent Review Organization (IRO) from the list of IROs approved by the Commissioner of Insurance. Assurant Health will provide any information requested by the IRO and will pay the cost of the independent review.

You will not be penalized for requesting an Independent Review. You may seek assistance from an individual of your choice and may submit additional information throughout the review process.

The IRO will make a determination to uphold or reverse the Assurant Health Level II appeal decision within fifteen (15) business days after the appeal is filed. The IRO will notify you within seventy-two (72) hours of making the decision.

### **Expedited External Review**

You have a right to request an expedited Independent Review if your physician certifies in writing that following the standard review process timeframe would jeopardize your life or health or your ability to reach and maintain maximum function. Please submit your written request, with the physician's certification and your authorization to release medical information, to us at the address shown above.

The IRO will make a determination to uphold or reverse the Assurant Health Level II appeal decision within seventy-two (72) hours after the appeal is filed. The IRO will notify you within twenty-four (24) hours after making the expedited decision.

If you submit new information to us for reconsideration, we will notify you of our decision within fifteen (15) days of receipt or within seventy-two (72) hours of receipt for expedited reviews. The Independent Review will be discontinued while the reconsideration is pending. If we uphold our original decision, you may request that the IRO resume the Independent Review.

The decision of the IRO will be binding. You may not file more than one request for independent review of the same Assurant Health decision. However, you do have the right to any other remedies allowed by law.

### **Plans subject to Health Care Reform**

After September 23, 2010, if your plan is subject to the Patient Protection and Affordable Care Act, the internal appeal process shall consist of one step. You may initiate the appeal process by contacting Assurant Health as described above.

Upon request, you may have reasonable access to all documents, records and other information relevant to your claim or request for benefits and obtain a copy of such information free of charge.

Additionally, you may be entitled to appeal notices in a language other than English. Contact Assurant Health if you need accommodations for non-English languages.

## Indiana EOB Appeal Language

### APPEAL PROCEDURE

If we have declined to provide benefits in whole or in part, you are entitled to a full and fair review of the claim determination. If you think this determination was made in error and would like to request a review, here are instructions on how to proceed. Please call our office or submit your request in writing. We would like to let you know you may submit any additional documentation you want reviewed. This may include medical records, physician reports and/or any information you believe would be helpful during the review. In addition, you may request to review the information we used to make our determination, as well as present any testimony you would like us to consider before making a decision.

You may submit the request for review, any supporting documentation and requests for information or testimony to:

Assurant Health Appeals  
P.O. Box 2806  
Clinton, IA 52733-2806

Upon receipt, we will complete a review and notify you of the results. Our determination will include our reasons for the decision, as well as any relevant contract language. If we continue to deny payment, you may be able to request an external review of your claim by an independent third party.

### PROVIDER DISPUTE MECHANISM

The provider has the right to enter into the dispute resolution process. The procedure for such a review is as follows: 1) The request should be in writing and you may submit any additional supporting documentation from other parties with your request (i.e. your physician report, medical records). 2) Upon receipt of your request, a review will be conducted. You will be notified of the results of this review. Our determination will include any specific reasons for the decision, including all pertinent policy provisions on which the decision was based.

Submit the request for review and any supporting written documentation to:

Assurant Health Appeals  
P.O. Box 2806 Clinton, IA 52733-2806

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company, Union Security Insurance Company and John Alden Life Insurance Company.