

Grievance/Appeal Procedures for Indiana Medical Expense Policies

Indiana has had grievance rules in effect for several years, but they have only applied to managed care plans. The rules were amended recently to apply to individual and group medical expense policies. Each time we take any action that qualifies within the definition of grievance below we are to send the Insured a copy of the notice of grievance rights, Form BD-158(Indiana). We have named Beth Martin as the contact person for grievances or appeals. Any grievances or appeals that arrive elsewhere in the Home Office should be referred to Beth Martin; however, we all need to be aware of these requirements and be able to answer basic questions from our Insureds.

Indiana's process is two-tier, with "grievance" as the first level and "appeal" being the second. A grievance is defined in the rule as:

Any dissatisfaction expressed by or on behalf of an Insured regarding:

- A determination that a service or a proposed service is experimental or investigational, inappropriate or not medically necessary.
- The availability of participating providers. (N/A to us)
- Handling or payment of claims.
- Matters pertaining to the contractual relationship between Insured and Illinois Mutual.

and for which the Insured can reasonably expect that the matter can be resolved or reconsidered.

"Appeal" is the second review level (after a grievance review).

In any grievance or appeal situation, we must act in accordance with the Insured's medical condition and consider the likelihood of permanent injury or death, deterioration or improvement of health status and the ability to reach and maintain maximum function. **In a situation involving medical urgency, refer to the Expedited Review paragraph on Page 3.**

GRIEVANCE PROCEDURE:

1. Acknowledgement of Receipt: The grievance is considered "filed" with us on the date we receive it, by mail, phone, fax or e-mail. Within 5 days of that "filing" date, we must send out an acknowledgement, restating the grievance, the date we received it and the name, mailing address and phone number, fax number and e-mail address of our contact person for grievances (Beth Martin). A sample of an acknowledgement is attached as Sample A. The acknowledgement can be sent from the Benefits Department before referring to Beth Martin's

attention. The file should be conspicuously tagged, so we can be sure the grievance is handled within the mandated time limits.

2. Initial Review: We should first direct our attention to the specific issue raised by the Insured. Is it a question of interpreting policy language? Is it addressing what is believed to be an error in calculation? In these types of situations, no additional investigation of the claim is necessary and we should proceed to Step No. 3.A., below. If additional investigation is necessary, proceed to Step No. 3.B., below.
3. Investigation:
 - A. Where no additional investigation is necessary, we should then determine if the error is ours or the Insured's. If ours, make necessary corrections and advise the Insured of the action we have taken. If the error is the Insured's, we should write to the Insured and thoroughly explain the situation. In either case, we must reach a decision within 20 business days of the "filing date" noted above.
 - B. If the grievance does raise questions that require further investigation, such as medical records or correspondence with a treating physician, we should make every attempt to obtain that information as quickly as possible. We still have a 20 business day time limit to finalize the grievance, but we can, if there are circumstances beyond our control, extend the time limit, one time, by 10 days. We must notify the Insured before the original 20 days expires that we are extending the time limit, and explaining what information we still need and why we need it (Sample C).
4. Grievance Decision: We are to review the grievance and all available information objectively and fairly, giving no deference to previous decisions. Once we have made a decision, within 5 business days we must send a notice to the Insured, including the following:
 - A re-statement of the Insured's grievance,
 - A description of the decision we have reached,
 - A description of the evidence or documentation that is the basis of our decision,
 - Notice of the right to appeal, and how to do so,
 - Name, address & phone number of someone the Insured can contact for more information about our decision and the right to appeal (any Benefits Department officer or manager, or Maureen Mulville in the Legal Department).

See Samples B-1 and B-2, attached.

APPEAL PROCEDURE:

1. Notice and Acknowledgement: The Insured need only notify us by mail, phone, fax or e-mail that he would like to have our grievance decision reviewed on appeal. Within 5 business days of this "filing date", we must acknowledge the appeal, identify our contact person as above, and

re-state the issue to be decided. We should also ask the Insured if he intends to personally appear at the appeal hearing, wants to be included by speakerphone, and if he intends to submit any additional information. If he does not plan to attend in person or by phone, we may ask him to waive the 72-hour notice requirement stated in #2, below.

2. Appeal Panel: The appeal is to be reviewed and decided by a panel consisting of:
 - One or more Illinois Mutual employees who has sufficient experience, knowledge and training to decide an appeal. This will be Beth Martin or, in her absence, Benefits Manager, Joan Stickelmaier, Maureen Mulville, General Counsel.
 - Someone who has knowledge of the relevant medical condition & treatment is licensed in the same profession and with a similar specialty as the provider originally involved in the claim, and has no business or personal relationship with the Insured or anyone else already involved in the case.
 - If there are appeals to be reviewed, the panel must meet at least once per month during normal business hours at a place convenient to the Insured, in case he wants to attend or otherwise communicate. The Insured must be notified at least 72 hours (by phone is OK) before the panels meets, unless the Insured has waived this requirement.

3. Appeal Decision: We are to reach a decision on the appeal within 45 business days of the filing date – no extensions. We are to notify the Insured of our decision within 5 business days after the decision is reached, and include in our notice:
 - A re-statement of the grievance reviewed on appeal,
 - A description of the decision we have reached,
 - A description of the evidence or documentation that is the basis of our decision,
 - Notice of other options available to the Insured (“You may consult with the Indiana Department of Insurance or your own attorney for other remedies that may be available to you.”)
 - Name, address & phone number of someone the Insured can contact for more information about our decision and the right to appeal (any Benefits Department officer or manager, or Maureen Mulville in the Legal Department).

EXPEDITED GRIEVANCES/APPEALS: If we are notified that the grievance/appeal involves a situation of medical urgency, we must act on the grievance/appeal with appropriate timeliness. , We are expected to resolve the grievance/appeal within the constraints of the Insured’s medical condition and the treatment needed. All communications are to be handled by phone, fax or e-mail, and follow-up time should be counted in minutes or hours, rather than days.

Any phone messages left in voice-mail must be responded to on the next business day. In all cases, the file must be thoroughly documented, noting the date and time when actions were taken. Also, once the grievance/appeal has been resolved, the file should be recorded in the Grievance Register.

Any questions regarding this Procedure should be referred to Beth Martin or Maureen Mulville.

External Grievance/Appeals: Covered individuals or a covered individual's representatives may appeal the decision of the Appeals Panel by submitting to us a written request for an external grievance review. This written request must be submitted not more than 120 days after the covered individual was notified of the Appeals Panel resolution. Once received, all required information surrounding the appeal will be sent to the Independent Review Organization. After an external grievance is filed, the Independent Review Organization shall make a determination within 15 business days in the case of a standard external grievance, and within 72 hours in the case of an expedited external grievance, to uphold or reverse the insurer's appeal resolution under [IC 27-8-28-17](#) based on information gathered from the covered individual or the covered individual's designee, the insurer, and the treating health care provider, and any additional information that the independent review organization considers necessary. The Independent Review Organization will review and communicate their appeal response directly to the covered individual or the covered individual's representative and the insurer within 72 hours of making a determination for standard external grievances and within 24 hours of making a determination for expedited external grievances. The selected Independent Review Organization will be chosen from the list of Certified Independent Review Organizations maintained by the Indiana Department of Insurance. A different Independent Review Organization will be selected for each external grievance request filed and will be sequentially rotated among all the certified independent review organizations before repeating a selection.

SAMPLE A: Acknowledgement Letter

We have received your (grievance/appeal) regarding _____ (here re-state the grievance as the Insured presented it to us) _____. We will give this matter our immediate attention. The person you may contact about this is:

Beth Martin, Vice President Benefits Department
Illinois Mutual Life Insurance Company
300 S.W. Adams Street
Peoria, IL 61634
Phone: (800)437-7355, Extension 196
Fax: (309) 673-8137
E-mail: bamartin@IllinoisMutual.com

Please notify us if you have any special needs that we should accommodate while handling your _____ (grievance/appeal) _____, such as language difficulties or physical impairments. If you have any additional information to submit, please do so immediately.

For a grievance acknowledgement only: We expect to be able to resolve your grievance within 20 business days. In the event that we are unable to get the information we need within that time period, we may take another 10 business days. In either event, we will notify you of the progress of your grievance.

For an appeal acknowledgement only: The hearing on your appeal will be held at Illinois Mutual's Home Office. The address is shown above. If you plan to attend the appeal hearing in person, or be included by speakerphone, please let us know so we can notify you of the date and time of the hearing. If not, we ask that you waive the requirement that we notify you 72 hours before the hearing. To waive this requirement, please sign at the bottom of this letter and return it in the enclosed envelope.

We would be happy to answer any questions for you. Please feel free to call or write to the address above.

Sincerely,

Beth Martin,
Vice President Benefits Department
Extension 196

For an appeal only – at the bottom of letter:

I do not plan to attend the hearing, either in person or by phone, and I hereby waive the requirement that Illinois Mutual notify me of the hearing 72 hours in advance.

Date: _____ Signature: _____

SAMPLE B: Decision Letter

B-1: Grievance Decision –

We have completed our grievance review regarding _____ (re-state the issue) _____. Our decision is .

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- If in Insured’s favor – state the action we will take, i.e., pay benefits for . . .
- If not in Insured’s favor – “that we are unable to honor your request that we (i.e., pay benefits for . . .) Our decision was based on . . . (advise of relevant documents reviewed and/or relevant policy provisions). You have the right to file an appeal of this decision. To do this, please contact me by phone, fax, mail or e-mail and advise me that you would like to have this decision reviewed on appeal. If you wish, you may discuss this decision with a representative of the Indiana Department of Insurance, Consumer Services Division, 311 W. Washington Street, Suite 300, Indianapolis, IN 46204-2787, Phone: 800-622-4461.

B-2: Appeal Decision –

We have completed our appeal review regarding _____ (re-state the issue) _____. Our decision is .

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- If in Insured’s favor – state the action we will take, i.e., pay benefits for . . .
- If not in Insured’s favor – “that the original decision on your grievance was correct because . . . (explain thoroughly). If you still disagree, there may be other options available to you. You should contact your own attorney, or the Indiana Department of Insurance, Consumer Services Division, 311 W. Washington Street, Suite 300, Indianapolis, IN 46204-2787, Phone: 800-622-4461.

Sign either B-1 or B-2:

Sincerely,

Beth Martin

Vice President Benefits Department

Phone - (800)437-7355, Ext. 196

Fax – (309)673-8137

E-mail – bamartin@IllinoisMutual.com

SAMPLE C – Extension Letter (send no later than 19th day after Filing Date)

Our investigation of your grievance is nearly complete. However, we have not yet received . . . (i.e., Dr. Smith’s records) . . . that we requested on Month XX, 2013. We need . . . (missing info) . . . in order to determine . . . (explain why the info is needed). We will complete our investigation no later than Month XX, 2013 (11 days from current date) and will contact you promptly as soon as we are able to resolve this matter. If you have any questions, please feel free to contact me.

Sincerely,

Beth Martin

Vice President Benefits Department

Extension 196

bamartin@IllinoisMutual.com