Grievance and Appeal Procedures

General Questions

If you have questions about your benefits, coverage, or the grievance and appeals process, SIHO can be reached by phone, email, mail, or fax. Our Member Services team is available to take your call during regular business hours, Monday through Friday.

Phone: 1-800-443-2980

Email: memberservices@siho.org

Mail: SIHO Insurance Services
P.O. Box 1787
Columbus, IN 47201

Appeals Fax: 317-860-3613

Grievance Procedures

An Enrollee may initiate a Grievance procedure by contacting us verbally or in writing. Enrollees have the right to appoint a Designated Representative to act on their behalf with respect to the Grievance by filing a signed form that may be obtained from SIHO upon request; provided, that if a provider files a Grievance relating to an Urgent Care Claim, then SIHO will treat such provider as a Designated Representative with respect to that matter even without the submission of a signed form.

SIHO will accept oral or written comments, documents or other information relating to the Grievance from the Enrollee or his/her Designated Representative by telephone, mail or other reasonable means. Enrollees are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Grievance.

Enrollees may obtain information regarding SIHO's Grievance procedures by calling the toll-free number on the back of the Enrollee's identification card during normal business hours.

Once a Grievance has been initiated by an Enrollee, SIHO will respond within 3 business days to acknowledge its receipt of the Grievance. Such response will be in writing, unless the Grievance was received orally, in which case the response may be oral. Grievances will be resolved within 20 business days after they are filed if all information needed to complete a review is available. If additional information is needed and the Grievance does not involve Precertification matters, SIHO may notify you before the 19th business day of its election to take an additional 10 business days to receive information and address the Grievance.

If an Enrollee's Grievance is denied in whole or in part, SIHO will notify the claimant, in writing or electronically, and the notice will include the following:

1. the specific reason or reasons for the denial;

2. reference to specific Health Plan provisions on which the denial is based;

3. a description of any internal rule, guideline, protocol or similar criterion relied on in making the Adverse Determination (or a statement that the information will be provided free of charge upon request);

4. an explanation of any scientific or clinical judgment on which the denial is based (or a statement that the explanation will be provided free of charge upon request);

5. a description of any additional material or information that the claimant may need to provide with an explanation as to why the material or information is necessary;

6. an explanation of the claimant's right to appeal under the Health Plan's appeal procedures, and the claimant's right to bring a civil action in federal court; and

7. the name, address, and phone number of a SIHO representative who can provide the claimant with more information about the decision and the right to appeal.

SIHO may provide the above information to the claimant orally, provided that a written notice is furnished to the claimant within 3 days after the oral notification.

Appeal Procedures

If SIHO's Grievance decision is satisfactory to the Enrollee, then the matter is concluded. If, however, the Enrollee is unsatisfied with SIHO's decision, the Enrollee may initiate an appeal of the Grievance in accordance with this Section. The Enrollee may also appeal an Adverse Determination in accordance with this Section.

1. General.

a. The Enrollee will have 180 days from the receipt of SIHO's decision to request an appeal.

b. The Enrollee or the Enrollee's Representative, including a provider (collectively, the "claimant"), may submit an appeal verbally or in writing. Any SIHO employee who has been unable to resolve the Grievance may take the appeal information.

c. All written notices requesting an appeal will be forwarded to an appeals coordinator.

d. All verbal requests must be documented by the SIHO associate who is assisting the claimant. Upon request, the notice will be forwarded to the appeals coordinator.

e. An acknowledgement notice will be sent to the claimant within 3 business days of receipt of the written or verbal appeal request.

2. Claimant's Rights on Appeal.

a. The claimant will have the opportunity to submit written comments, documents, or other information relating to the Grievance or Adverse Determination. All such information must be submitted by the Enrollee, the Enrollee's representative or provider within 180 days of receipt.

b. Upon request and free of charge, the claimant will be provided with reasonable access to and copies of all documents, records, and other information relevant to the Grievance.

c. The review will take into account all comments, documents, records and other information the claimant submits, whether or not presented or considered in the initial determination.

d. No deference will be afforded to the initial determination.

e. The review will be conducted by a person or persons different from the person who made the initial determination and who is not the original decision-maker's subordinate.

f. If the decision is made on the grounds of a medical judgment, SIHO will consult with a health care professional with appropriate training and experience. The health care professional will not be the individual who was consulted during the initial determination or that person's subordinate.

g. SIHO will provide the claimant with the name of any medical or vocational expert who advised SIHO with regard to the Grievance or Adverse Determination.

3. Appeals Hearing Committee.

a. The appeals coordinator will investigate the issue and gather the data needed to review the circumstances surrounding the appeal.

b. The appeals coordinator will convene an Appeals Hearing Committee consisting of at least one person. None of the Committee will have been involved in any of the previous determinations, or involved in a direct business relationship with the Enrollee or health care provider whose care is at issue.

c. The appeals coordinator will send notice of the hearing date, time, and location to the claimant, at least 72 hours in advance of the hearing. The hearing process will make any reasonable accommodations to convenience the claimant, including arranging for a teleconference in situations where the claimant is unable to attend.

d. If the claimant attends the appeal hearing or participates via teleconference, the claimant may present his case. The hearing provides an opportunity for the claimant to explain his position as well as allow the Appeals Hearing Committee members to ask the claimant any pertinent questions they may have.

4. Notification of Resolution of Appeal.

a. Pre-Service Appeals: In the case of an Appeal not involving urgent care, SIHO will notify the claimant of its decision within 30 days after it receives the request for review and sufficient information to make its determination.

b. Urgent Care Appeals: In the case of an Appeal that relates to urgently needed care, SIHO will notify the claimant of its decision within 48 hours after it receives the request for review and sufficient information to make its determination.

c. Other Appeals: In the case of all other Appeals, SIHO will notify the claimant within 30 days after it receives the written request for review and sufficient information to make its determination.

5. Expedited Appeals.

a. A claimant may request an expedited appeal or SIHO may independently determine that the process should be expedited. The expedited process is considered a stand-alone procedure and is in lieu of the standard appeal procedure.

b. The claimant may request an expedited appeal orally or in writing. All information, including SIHO's decision, may be transmitted between the claimant and SIHO by telephone, facsimile, or other available similar method.

c. Resolution of the expedited appeal will be made as expeditiously as the appellant's health warrants but will occur no later than 48 hours after the filing of the appeal.

6. Notice of Decision on Appeal.

If an appeal is denied, SIHO will notify the claimant, in writing or electronically. The notice will contain the following information:

a. the specific reason(s) for SIHO's denial;

b. a reference to the specific Health Plan provision(s) on which the denial is based;

c. a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the Adverse Determination;

d. an explanation of any scientific or clinical judgment on which the denial is based;

e. a statement that the claimant is entitled to receive, upon request and without charge, reasonable access to and copies of all documents, records or other information relevant to the appeal;

f. a statement describing the voluntary appeal procedures via the external review offered by the Health Plan and the claimant's right to obtain information about the procedures;

g. the statement that "You or 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";

h. a statement describing the claimant's right to bring a civil suit under federal law; and

i. the name, address and telephone number of the appeals coordinator whom the claimant may contact for more information.

7. External Review of Appeals Process.

a. If the claimant is dissatisfied with the Appeal Hearing Committee's resolution, and the matter involves:

(i) an Adverse Determination; or

(ii) a rescission of coverage by SIHO

he or she may file a written request to initiate an External Review Appeal. This request must be filed no later than 120 days after the claimant is notified of the resolution of the Appeal Hearing Committee's decision. External Review Appeal is not available for matters other than those specified in this paragraph.

b. The claimant may not file more than one (1) External Review Appeal request on the same appeal.

c. Upon receipt of the request for External Review Appeal, the appeals coordinator will select an independent review organization (IRO) that is certified to perform external review in the State of Indiana.

d. The IRO will assign a medical review professional who is board certified in the applicable specialty for resolution of the appeal.

e. The IRO and the medical review professional conducting the external review may not have a material professional, familial, or financial, or other affiliation with SIHO; any officer, director, or management employee of SIHO; the physician or the physician's medical group that is proposing the service; the facility at which the service would be provided; or the development or manufacture of the principal drug, device, procedure, or other therapy that is proposed by the treating physician. However, the medical review professional may have an affiliation under which the medical review professional provides health care services to Enrollees of SIHO and may have an affiliation that is limited to staff privileges at the health facility if the affiliation is disclosed to the claimant and to SIHO before commencing the review and neither the claimant nor SIHO objects to the affiliation.

f. A claimant who files an appeal under this final alternative is not subject to retaliation for exercising his or her right to an appeal by an IRO. The claimant may be permitted to utilize the assistance of other individuals, including physicians, attorneys, friends, and family members throughout the external review process. The claimant shall be permitted to submit additional information relating to the proposed service throughout the review process and may cooperate with the IRO by providing any requested medical information or authorizing the release of necessary medical information.

g. SIHO shall cooperate with the IRO by promptly providing any information requested by the IRO.

h. The IRO shall make a determination to uphold or reverse SIHO's appeal resolution based on information gathered from the claimant, SIHO, the treating physician, or any additional information that the IRO considers necessary and appropriate. For standard appeals, the determination shall be made within 15 business days from the filing date of the request for

external review. For expedited appeals, the determination shall be made within 72 hours after the external review request is filed.

i. When making the determination of the resolution of the appeal, the IRO shall apply the standards of decision making that are based on objective clinical evidence and the terms of the appellant's benefit contract.

j. The IRO shall notify SIHO and the claimant of the determination made under this section within 72 hours after making the determination. For expedited appeals, the notification will occur within 72 hours of the determination. The result of the determination is binding on SIHO.

k. If at any time during the external review process the claimant submits information to SIHO that is relevant to SIHO's previous appeal resolution and was not considered by SIHO during the appeals hearing phase, SIHO shall reconsider the previous resolution under the appeals hearing process. The IRO shall cease the external review process until the reconsideration by SIHO is completed.

l. If additional information from the claimant results in SIHO's reconsideration of the appeal at the hearing level, SIHO will notify the claimant of its decision within 15 days after the information is received. If the appeal is related to an Urgent Care Claim, SIHO will make a determination within 72 hours of receipt of the additional information.

m. If the reconsideration determination made by SIHO is adverse to the claimant, the claimant may request that the IRO resume the external review.