

ADVANTAGE Health Solutions, Inc. SM
POLICY AND PROCEDURE

Policy Number: AG-001		
Policy Name: Commercial Member Grievances and Appeals for Fully Funded Lines of Business		
Policy Approved by:	Dorrie Hamm Director of Operations	Replaces Policy #: MM-001.1; MM-027
Signature: 	Date: 06/01/16	Effective Date: 12/27/02 Revision Date: 03/11/04; 05/23/07; 01/04/11; 06/25/12; 05/15/03; 01/20/14; 07/15/14; 09/15/14; 03/30/15; 08/27/15; 06/01/16 Review Date: 10/23/04; 12/21/05; 05/23/07; 03/15/10; 06/25/12; 06/04/13; 9/30/2014
Applies to: <input checked="" type="checkbox"/> Fully Funded Products		

PURPOSE:

The purpose of this procedure is to:

- Establish a formal process for the timely resolution of member grievances and appeals in accordance with 45 CFR Part 147 under the Patient Protection and Affordable Care Act (PPACA) or (ACA); IC 27-13-10-1 through IC 27-31-10-3 and IC 27-13-10.1 (External Review) and Sections 502 and 503 of the Employee Retirement Income Security Act (ERISA).
- Ensure the grievance and appeal procedures facilitate a thorough evaluation from both sides.
- Ensure grievances and appeals involving clinical issues (e.g. timeliness of care, access to care or appropriateness of care) include a review of the clinical judgments involved in the case.
- Establish a procedure for tracking and trending grievances and appeals to identify opportunities for quality improvement system wide.

POLICY:

ADVANTAGE Health Solutions, Inc. SM (herein also referred to as “ADVANTAGE”) has established a formal grievance process to assist members and subscribers in filing grievances. This grievance procedure applies to all grievances about coverage or dissatisfaction under the ADVANTAGE commercial fully funded products. Any member who is dissatisfied with ADVANTAGE’s performance, care and/or service may begin the grievance process by requesting a re-evaluation verbally or in writing, by facsimile or by other means of electronic communication. A grievance is considered to be filed on the date it is received, either by telephone or in writing.

A grievance is defined in 760 IAC 1-59-3 as any dissatisfaction, expressed orally or in writing by or on behalf of a member regarding the:

- a. availability, delivery, or quality of health care services;
- b. handling or payment of claims for health care services; or
- c. matters pertaining to the contractual relationship between:
 - (i) a member and ADVANTAGE; or
 - (ii) a group or individual contract holder and ADVANTAGE;
- d. Any concerns regarding confidentiality of information.

ADVANTAGE will ensure members receive complete and accurate information regarding benefits, exclusions, rights and responsibilities, and the grievance and appeal process. Information is provided to members in the Certificate of Coverage, Member Reference Guide, provider office postings and other subsequent member communications.

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ADVANTAGE will receive, acknowledge and resolve all member grievances in accordance with the requirements set forth by the Patient Protection and Affordable Care Act 45 CFR Part 147; State of Indiana, IC 27-13-10-8; and Sections 502 and 503 of the Employee Retirement Income Security Act (ERISA).

ADVANTAGE shall not take action against any provider solely on the basis of the provider assisting or representing a member or subscriber in filing a grievance in accordance with IC 27-13-8-2 through IC 27-13-10.

ADVANTAGE may elect to offer via grievance or appeal review benefits for services, pursuant to an approved alternative treatment plan for a member. Alternative benefits are provided at the sole discretion of ADVANTAGE, and only when and for so long as ADVANTAGE determines that alternative services are *medically necessary*.

If ADVANTAGE elects to provide alternative benefits for a patient in one instance, it will not be obligated to provide the same or similar benefits for other patients in another instance, nor will it be construed as a waiver of ADVANTAGE's right to administer the benefits thereafter in strict accordance with its express terms. Further, if ADVANTAGE elects to provide alternative benefits for a patient, it will not obligate itself to provide the same benefits for the same patient without prior *authorization* from ADVANTAGE.

PERFORMANCE STANDARDS:

- Allowance of 180 days after notification of the denial for the member to file either a grievance or appeal. The member has 180 days from the date of the initial adverse determination to file a Level 1 grievance and 180 days from the date of the Level 1 grievance decision to file a Level 2 appeal. The member additionally has 180 days from the date of a Level 2 appeal decision to submit a written request for review by an Independent Review Organization.

- A letter acknowledging receipt of the grievance (Level 1) or appeal (Level 2) is mailed to the member within three (3) business days.

- **EXPEDITED** Grievances/Appeals :

ADVANTAGE offers the member an expedited grievance or appeal for any urgent care request. A claim involving urgent care is a claim for medical care or treatment with respect to which application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, based on a prudent layperson's judgment or in the opinion of a physician with knowledge of the member's medical condition would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request including all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from the facility

An expedited review begins when a member, a representative of the member, or a practitioner acting on behalf of the member requests an expedited appeal either verbally, by facsimile, in writing or by any means of electronic communication.

ADVANTAGE must make the expedited grievance or appeal decision as expeditiously as the medical condition requires, but no later than 72 hours after the request unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan or health insurance coverage. All internal levels of appeal must be conducted and a decision made within a total of 72 hours from receipt of original request.

Members may also request an expedited external review at the same time as the expedited internal appeals process if this is an urgent care situation and if the case is subject to external review.

- **PRE-SERVICE** Level 1 grievances and Level 2 appeals:

A pre-service grievance or appeal is a request to change an adverse determination for care or services in advance of the member obtaining the care or services. ADVANTAGE resolves pre-service grievances and appeals within 15 calendar days from receipt of the request at each level of review (first and second levels).

- **POST-SERVICE Level 1 Grievances:**

A post-service grievance is a request to change an adverse determination for care or services that have already been received by the member. ADVANTAGE resolves Level 1 grievances within 20 business days after the grievance is filed. If we are unable to make a decision regarding the grievance within the 20 day period due to circumstances beyond our control, then we shall:

- (1) Notify the member in writing advising of the reason for the delay before the 20th business day, and
- (2) Issue a written decision within an additional ten (10) business days.

- **POST-SERVICE Level 2 Appeals:**

ADVANTAGE resolves second level post-service appeals within 30 calendar days. Members are mailed a certified letter notifying them of the date and time of the Level 2 Appeals Panel meetings no later than seven (7) calendar days prior to the meeting. Members have the opportunity to appear or otherwise communicate with the Panel at a time during normal business hours (Mon-Fri., 8AM-5PM, EST). The member may also submit written comments, documents or other information relating to the appeal.

- **EXTERNAL appeal:**

Members may request in writing an external review by an Independent Review Organization (IRO) within 180 days of the Level 2 determination. ADVANTAGE shall fully cooperate with an IRO. A member who files an external appeal shall not be subject to retaliation for exercising the member's right to appeal and be permitted to utilize the assistance of other individuals, including physicians, attorneys, friends, and family members throughout the review process. Members are permitted to submit additional information throughout the review process. The member may not file more than one external review request for each grievance/appeal.

PROCEDURE:

Requirement for filing a grievance

- 1) A grievance may be filed orally, including by telephone or in writing, including by a facsimile or electronic means of communication. The member must include member identification number when filing a grievance.
- 2) A grievance may be filed by a member or a representative of the member, including a health care provider acting on behalf of the member. Under certain circumstances, the member may be required to sign a release form to authorize the representative to act on behalf of the member. (*Attachment A*)
- 3) A member may ask for assistance with filing a grievance by the Appeals Specialist toll-free 1-888-806-1029 (for hearing impaired, TDD 1-800-728-1777). If the member has limited use and/or understanding of English, ADVANTAGE will provide interpreter services to the member or member's representative through a third party translation service. Interpreter services are available at no charge to the member.

Access to Plan Appeals and Grievances Staff

- 1) ADVANTAGE has established a toll-free number 1-888-806-1029 where grievances and appeals may be filed and information obtained about the grievance/appeals process. The Member Services toll-free number (1-800-553-8933) is also listed on the member's ID card. Members may obtain assistance in filing a grievance or appeal by calling the Member Services toll-free number.
- 2) This toll-free number is active and staffed at a minimum of 40 hours per week, M-F 8:00 AM - 5:00,PM EST, by the Appeals & Grievance (A&G) staff. These individuals are knowledgeable about the grievance procedures and applicable state laws and regulations.
- 3) These individuals are also available to callers that might initially contact a Member Services Representative. The toll-free number is available to callers 24 hours per day, 365 days per year. This toll-free number is equipped with voice mail, which instructs the caller to leave a detailed message and phone number for return call.

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ADVANTAGE must accept grievances in English and the language of any other major population groups served by ADVANTAGE.

PROCESS AND INVESTIGATION – GRIEVANCE (FIRST-LEVEL APPEAL)

The following process begins upon the date ADVANTAGE receives the request for grievance:

<i>Responsible Party</i>	<i>Task(s)</i>
Appeals Specialist	<ol style="list-style-type: none"> 1. The Appeals Specialist receives a Level 1 grievance (or appeal) from a member verbally or in writing, including telephone, facsimile or electronic means of communication. <ol style="list-style-type: none"> a. If the grievance request is in writing, the request is date-stamped with the date by ADVANTAGE. b. The Appeals Specialist initiates the grievance process by completing the <i>Appeals and Grievances Intake form (Intake Form)</i>, including the date of receipt of any verbal request made to ADVANTAGE. (Attachment B-1). 2. The grievance request is entered into the Appeals & Grievances Application (Application). (Attachment B-2) The Application is a combination of data entered into an internal application and information entered into the QNXT system. The Application is the permanent record of grievance requests, investigational activities, resolutions and timeframes. The Application includes the following data elements: <ul style="list-style-type: none"> • Name of the member who filed the appeal/grievance; • Appeal staff assigned to the case • Member's Plan ID number; • General description of the basis of the grievance, using the categories required by the Department of Insurance Grievance Reporting format (Section 760 IAC 1-59-14); • Clinical vs. benefit • Date of service • Date received; • Description of resolution; • Date appeal was resolved; 3. Creates a file for all documentation concerning the member grievance. The file will include: (Attachment C) <ul style="list-style-type: none"> • Copy of the written grievance request or the <i>Intake Form</i> (whichever is applicable); • Copy of acknowledgement letter; and • Copies of all documentation, correspondence, consultations, or evidence submitted by member, providers or other individuals regarding the grievance. 4. Sends an acknowledgement letter to the member within three (3) business days of receipt of the grievance (Attachment D). Includes <i>Notice of Appeals Rights</i> document (Attachment E) 5. Conducts research on the grievance including reviewing all documentation pertaining to the grievance. <ul style="list-style-type: none"> • Accesses and reviews case history. • Obtains all records concerning the grievance. • Reviews any new information filed with the grievance.

<i>Responsible Party</i>	<i>Task(s)</i>
	<ul style="list-style-type: none"> • Requests additional documentation as needed (e.g., request for medical records, contacts member’s PCP to confirm any outstanding issue). <p>6. For clinical in nature cases, summarizes the facts of the case on the clinical panel review sheet.</p> <p>7. For those grievances which are <i>not</i> resolved prior by ADVANTAGE (some grievances may be favorably resolved by ADVANTAGE without the Level 1 Grievance Panel review based on the circumstances of the issue), forwards the grievance file and all documentation to the Level 1 Grievance Panel. No person involved in the prior adverse decision is involved in the review of the grievance. No person involved in the decision of the grievance is the subordinate of the person involved in the initial adverse decision.</p>
Level 1 Grievances Panel	<p>8. Reviews all documentation pertaining to the grievance file.</p> <p>9. Consults with other involved ADVANTAGE departments, as needed.</p> <p>10. Forwards case to another physician or appropriate medical staff for recommendation, if needed. If the Medical Director was involved in the initial decision, the file will be referred to a physician in the same general specialty as would manage the medical condition.</p> <p>11. Within a total of 72 hours from receipt of an expedited grievance/appeal, or within 15 calendar days from receipt of a pre-service grievance or 20 business days from receipt of a post-service grievance, renders a decision upon review of all documentation and evidence. A copy of Panel notes (if any) and documented decision are filed in the member's grievance file.</p>
Appeals Specialist	<p>12. Notifies the member within five (5) business days from panel decision. If ADVANTAGE is unable to make a decision due to circumstances beyond ADVANTAGE’s control, then ADVANTAGE will notify the member with the reason for delay by the 20th business day of a post service grievance; the 15th calendar day of a pre-service grievance. ADVANTAGE must issue a written decision regarding the grievance within an additional 10 business days. (Attachments F; F-1). Include Appeal Rights for an upheld decision (Attachment E). Include all of the following information in the written notification:</p> <ul style="list-style-type: none"> • The decision reached by ADVANTAGE following the investigation including the specific reason(s) for the decision in easily understandable language; • Statement of ADVANTAGE's understanding of member's grievance including a reference to the benefit provision, guideline, protocol or other similar criterion on which the decision was based; • Notification that the member is entitled to receive, upon request, reasonable access and copies of all documents relevant to the grievance. Relevant documents include documents or records relied upon in making the appeal decision and documents and records submitted in the course of making the appeal decision. Notification that the member, upon request, can obtain a copy of the actual benefit provision, guideline or protocol or other similar criterion on which the appeal decision was based. The member has no financial cost for this request; • A list of titles and qualifications of individuals participating in the review. When requested by the member, ADVANTAGE shall provide the identity of any experts whose advice was obtained on behalf of ADVANTAGE without regard to whether the advice was relied upon in making the determination;

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<i>Responsible Party</i>	<i>Task(s)</i>
	<ul style="list-style-type: none"> • Notice of the member’s or subscriber’s right to appeal review before the Level 2 Appeals Panel, when the denial is upheld; • Information regarding the member’s potential right to bring a civil action under Section 502 (a) of ERISA; • A description of the procedure to appeal, including how to file an appeal; (<i>Attachment E</i>) and • The Appeals Specialist name, Department, address and toll-free telephone number to obtain more information about the decision or the right to appeal. <p>13. Forwards a copy of the grievance decision letter to the appropriate delegate PHO, when applicable.</p> <p>14. Updates the Application with the result of the grievance and the date of the response to the member.</p> <p>15. Places all documentation in the member’s file. Stores the file in secured files.</p>

EXPEDITED GRIEVANCES/APPEALS LEVELS 1 AND 2

ADVANTAGE offers the member an expedited appeal for any urgent care request A claim involving urgent care is a claim for medical care or treatment with respect to which application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, based on a prudent layperson’s judgment or in the opinion of a physician with knowledge of the member’s medical condition would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request including all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from the facility

An expedited review begins when a member, a representative of the member, or a practitioner acting on behalf of the member requests an expedited appeal either verbally, by facsimile, in writing or by any means of electronic communication.

ADVANTAGE must make the expedited grievance or appeal decision as expeditiously as the medical condition requires, but no later than 72 hours after the appeal is initiated, unless the member fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan or health insurance coverage.

The member may also begin an expedited external review at the same time as the expedited internal appeals process if this is an urgent care situation and if the case is subject to external review.

<i>Responsible Party</i>	<i>Task(s)</i>
Appeals Specialist	<p>1. The grievance is handled in same manner identified above in steps 1-15. The timeframe for completing the expedited grievance is a total of 72 hours (encompassing both internal levels of appeals). The member is verbally notified of the decision within the 72 hour time period and sent written confirmation of the decision within 3 calendar days of providing notification of the decision, if the initial decision was not in writing.</p>

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STANDARD RECONSIDERATION BY THE LEVEL 2 APPEALS PANEL

<i>Responsible Party</i>	<i>Task(s)</i>
Appeals Specialist	<ol style="list-style-type: none">1. Receives a verbal or written request from a member for a re-review of their grievance by the Level 2 Appeals Panel.2. Updates the Application by entering the date the request for Panel review was received.3. Obtains and reviews the initial grievance file for information on the grievance. Document the substance of the appeal and actions previously taken.4. Sends an acknowledgment letter to the member within three (3) business days of receipt of the request for review by the Panel (Attachment G). This letter includes the member's Appeals Rights (Attachment E).5. Places a copy of the acknowledgment letter in the member's file. Contacts the member to determine if the member wishes to attend the hearing and, if so, to schedule a time accordingly. The hearing will take place within 72 hours from receipt of an expedited Level 2 appeal request; within 15 calendar days for a pre-service appeal; or within 30 calendar days for a post-service appeal. The Level 2 Appeals Panel will meet at a time during normal business hours (Mon-Fri, 8:00 AM-5:00 PM, EST). Arranges a teleconference if the member or their representative is unable to attend the hearing and wishes to participate.6. Schedules the Panel meeting and ensures a quorum will be present by securing commitments from Panel members who plan to be present on the scheduled date and time.7. Notifies the member by certified mail of the Panel meeting, time and place of the hearing, and conference call telephone number for participation. Sends the letter no later than seven (7) calendar days prior to the Panel meeting. (Attachment F). The member may waive the "72-hour" required notice of the meeting of the panel for an expedited appeal.8. Requests additional documentation as necessary, either from the member, providers or others associated with the case.9. Compiles a summary of the substance of the appeal, the review process and findings for presentation to the Panel.10. Sends a complete packet of appeals information to each member, prior to the Panel meeting. Include in the packet the meeting agenda and a summary of each grievance to be discussed at the meeting.11. If the grievance involves proposal, refusal, or delivery of a health care procedure, treatment, or service, the Panel must include at least one individual with:<ul style="list-style-type: none">• Knowledge in the medical condition, procedure or treatment at issue;• Same licensed profession as the health care provider who proposed, refused, or delivered the health care procedure, treatment, or service that is the basis of the underlying grievance12. Individuals may not be appointed to the panel if:<ul style="list-style-type: none">• He/she has a direct business relationship with the member or the health care provider who proposed, refused, or delivered the health care procedure, treatment, or service that is the basis of the underlying grievance;• He/she was involved in the matter of the underlying grievance;

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<i>Responsible Party</i>	<i>Task(s)</i>
	<ul style="list-style-type: none"> • He/she was involved in the investigation or resolution of the underlying grievance. <i>Panel members shall include representatives with knowledge in the medical condition, procedure or treatment at issue;</i> • No person involved in the prior adverse initial denial or grievance decision is involved in the review of the appeal. No person involved in the decision of the appeal is the subordinate of the person involved in the initial adverse or grievance decision. <p>13. The Level 2 Panel meets as needed to perform grievance appeals review. A quorum is necessary to conduct a meeting, which is defined as 1/2 of the Level 2 Panel. The Level 2 Panel meets at a time during the normal business hours and invites the member to appear before or otherwise communicate with the panel to the extent reasonably possible.</p> <p>14. Presents each case file for review by summarizing the cover sheet, correspondence, medical records and other supporting information. Brings complete hardcopy files of each case to be presented.</p>
Level 2 Appeals Panel	15. Reviews the case and makes a decision on resolution of the appeal within 72 hours from receipt of an expedited appeal, within 15 calendar days for a pre-service appeal or within 30 calendar days for a post-service appeal.
Member or Representative	16. Presents testimony related to the grievance. Answer questions posed by the Panel.
Appeals Specialist	<p>17. Documents in the Application the Panel decision including any additional instructions for further investigation or follow-up. Records the result (approved or denied) of the hearing and the date of the response letter in the Application.</p> <p>18. Notifies the member within five (5) business days from panel decision (<i>Attachment H</i> for an upheld decision; include Appeals Rights (<i>Attachment E</i>); <i>Attachment F</i> reversal letter for a reversed decision). If ADVANTAGE is unable to make a decision due to circumstances beyond ADVANTAGE's control, then ADVANTAGE will notify the member with the reason for delay by the 30th calendar day of a post service grievance; the 15th calendar day of a pre-service grievance. . ADVANTAGE must issue a written decision regarding the grievance within an additional 10 business days.</p> <ul style="list-style-type: none"> • The decision reached by ADVANTAGE following the investigation including the specific reason(s) for the decision in asily understandable language; • Statement of ADVANTAGE's understanding of member's appeal including a reference to the benefit provision, guideline, protocol or other similar criterion on which the decision was based; • Notification that the member is entitled to receive, upon request, reasonable access and copies of all documents relevant to the grievance. Relevant documents include documents or records relied upon in making the appeal decision and documents and records submitted in the course of making the appeal decision; • Notification that the member, upon request, can obtain a copy of the actual benefit provision, guideline or protocol or other similar criterion on which the appeal decision was based; • A list of titles and qualifications of individuals participating in the review. When requested by the member, ADVANTAGE shall provide the identity of

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<i>Responsible Party</i>	<i>Task(s)</i>
	<p>any experts whose advice was obtained on behalf of ADVANTAGE without regard to whether the advice was relied upon in making the determination;</p> <ul style="list-style-type: none"> • Notice that the member may have a right to review by an independent review organization when the denial is upheld, depending on the type of appeal; • Information regarding the member’s right to bring a civil action under Section 502 (a) of ERISA; • The Appeals Specialist’s name, Department, address and telephone number to get more information on the decision. <p>19. Inserts a copy of the letter in the grievance file and forwards a copy of the appeal decision letter to the delegate PHO, when appropriate.</p> <p>20. Close the grievance file on the log and document actions taken.</p>

STANDARD EXTERNAL REVIEW

A member or a member’s authorized representative must exhaust the Plan’s internal appeal process before a standard external review is available.

The member is made aware of the right for external review for certain appeals and how to request such through:

- Information on how to review or obtain member’s right to an external appeal through the annual Member Newsletter.
- The member’s rights to an external review are posted on ADVANTAGE’s website year round.
- The member is provided information on how to file an external review in the Notice of Appeals Rights documentation provided to a member when an internal grievance/appeal has been filed by the member.

A member is entitled to pursue an external review of an appeal regarding the following decisions of an HMO or an agent of the HMO regarding a service proposed by the treating physician:

- An adverse utilization review determination, as defined in IC 27-8-17-8;
- An adverse determination of medical necessity; or,
- A determination that a proposed service is experimental or investigation (IC 27-13-10.1-1)
- The HMO’s decision to rescind an individual contract or a group contract.

The request for a standard external review must be submitted to ADVANTAGE in writing not later than 180 days after the member is notified of the Level 2 appeal resolution. The member is not required to bear any costs, or filing fees associated with the Independent Review Organization (IRO) review.

The request may be expedited for an appeal related to an illness, a disease, a condition, an injury or a disability that would seriously jeopardize the member's life or health or ability to reach and maintain maximum function.

If a member has the right to external review under Medicare, they may not request an external review through the plan.

A member may not file more than one external review request for each grievance.

The member must be permitted to cooperate with the IRO by providing requested medical information or by authorizing the release of medical information.

<i>Responsible Party</i>	<i>Task(s)</i>
<p>Appeals Specialist</p>	<ol style="list-style-type: none"> 1. Receives a written request from a member or the member's representative for an external review. 2. Determines if the request is valid <ul style="list-style-type: none"> • Within five (5) business days following the date of receipt of the standard external review request, the Appeals Department must complete a preliminary review of the request to determine whether: <ul style="list-style-type: none"> ▪ The member is or was covered under ADVANTAGE at the time the health care item or service was provided. ▪ The denial does not relate to the member's failure to meet the requirements of eligibility under the terms of this Plan ▪ The member has exhausted ADVANTAGE's internal appeal process. ▪ The member has provided all the information and forms required to process the request. 3. Within one (1) business day after completion of the preliminary review, the A&G Department must issue a written notification to the covered person: <ul style="list-style-type: none"> • If the request is complete but not eligible for standard external review, such notification will include the reasons for ineligibility. (<i>Attachment J</i>) <ul style="list-style-type: none"> ▪ If the request is not complete, such notification will describe the information or materials needed to make the request complete and allow the covered person to submit the documentation within the initial 180 days filing period or within the forty-eight (48) hour period following the receipt of the notification, whichever is later. ▪ If the request for standard external review is complete and eligible, the Appeals Department will assign an independent review organization to conduct the review (<i>Attachment I</i>) 4. Updates the Application by entering the date the request for external review was received. 5. Initiates the selection of the independent review organization (IRO) from the Indiana Department of Insurance's (IDOI) list of certified independent review organizations. <ul style="list-style-type: none"> • Rotates the choice of an independent review organization among all certified independent review organizations for each appeal filed before repeating a selection. Follows the sequential rotation order as listed by IDOI. There is no repeating an IRO until all IROs have been assigned. <ul style="list-style-type: none"> ▪ Informs ADVANTAGE Director of Operations of the need to contact an IRO for a requested external review. • Places a telephone call to the next IRO on the rotation list. Allows 48 hours for IRO to contact ADVANTAGE to initiate external review process. <ul style="list-style-type: none"> ▪ If the selected IRO does not contact ADVANTAGE within the 48 hour time span, generate an e-mail to IDOI designated contact informing IDOI of the lack of response from the contacted IRO and the need to contact the next IRO in the sequential list. <ul style="list-style-type: none"> ▪ Informs IDOI in the e-mail of the name of the next IRO to be contacted using the rotation list. Subject line in the e-mail should read "IRO Rotation Modification". Include: <ul style="list-style-type: none"> ▪ The name of the IRO being skipped ▪ An explanation as to why the IRO is being skipped

<i>Responsible Party</i>	<i>Task(s)</i>
	<ul style="list-style-type: none"> ▪ The name of the substituted IRO ▪ Date the assignment was made to the substituted IRO ▪ Informs ADVANTAGE Director of Operations of the issue. ▪ Contacts next IRO on the rotation list and once again initiates external review process. • The independent review organization and the medical professional conducting the external review may not have a material professional, familial, financial or other affiliation with any of the following: <ul style="list-style-type: none"> ▪ Any officer, director or management employee of the HMO; ▪ The physician or the physician's medical group that is proposing the service; ▪ The facility at which the service would be provided; ▪ The development or manufacture of the principal drug, device, procedure or other therapy that is proposed by the treatment physician. • The medical review professional may have an affiliation under which he or she provides health care services to members of the HMO if the affiliation is disclosed to the HMO and member before commencing the review and neither objects. <ol style="list-style-type: none"> 6. Obtains and reviews the initial grievance/appeal file for information on the grievance/appeal. Documents the substance of the appeal and actions previously taken. 7. Promptly provides all information and documentation requested by the independent review organization. 8. Places a copy of communication with the independent review organization in the member's file. <ul style="list-style-type: none"> • If during an external review, the member submits additional relevant information to ADVANTAGE that is relevant to the resolution, ADVANTAGE shall reconsider its resolution. The independent review organization shall cease the external review until the reconsideration is completed • ADVANTAGE shall reconsider the resolution and notify the member of the decision within 48 hours after the information is submitted, in the case of an expedited appeal, and within 15 days in the case of a standard appeal. ADVANTAGE shall make claim payment within the timeframe set forth by the independent review organization. • If the reconsideration is adverse to the member, the member may request the independent review organization to resume the external review. 9. Receives decision from the independent review organization, and initiate any actions required by the external review resolution. 10. Updates the Appeals Application with resolution of the external review.

EXPEDITED EXTERNAL REVIEW

The member may also begin an expedited external review at the same time as the expedited internal appeals process if this is an urgent care situation and if the case is subject to external review.

Policy Name: Commercial Members Grievances and Appeals for Fully Funded Lines of Business
Policy Number: AG-001
Effective/Revision Date: 01/20/14; 07/15/14; 09/15/14; 03/30/15; 08/27/15; 06/01/16

The request may be expedited for an appeal related to an illness, a disease, a condition, an injury or a disability that would seriously jeopardize the member's life or health or ability to reach and maintain maximum function.

<i>Responsible Party</i>	<i>Task(s)</i>
	<ol style="list-style-type: none"> 1.) Receives request for expedited external review 2.) Verifies request is valid for expedited review. If the request meets the criteria for an expedited review, proceed to next step 3.) If the request does not qualify for an expedited review but does qualify for a standard external review, notifies requester and initiates steps outlined above under STANDARD EXTERNEL REVIEW. 4.) Immediately places a telephone call to the next IRO on the rotation list. Informs IRO of the need for an expedited review determination within 72 hours after the appeal is filed. (IC 27-13-10.1-4) 5.) Forwards all case documentation to the IRO for review. 6.) Calls requestor to inform of the name and contact information for the IRO should requestor decide to contact IRO with additional information. 7.) Receives decision from the independent review organization, and initiate any actions required by the external review resolution. Member is notified by IRO of the decision. 8.) Updates the Appeals Application with resolution of the external review.

At least annually, ADVANTAGE notifies its members of the availability of the right to external, independent review for certain appeals. Members are notified via the annual Member Newsletter to log on to ADVANTAGE’s website to learn about external reviews. In addition, the Notice of Appeals rights included in correspondence with members throughout the internal appeals process informs the member of the rights to an independent review and how to initiate such a request. (Attachment C)

Maintenance of IRO Listing

Ongoing monitoring of the IDOI listing of contracted IROS is required. The Appeals Specialist will ensure the most updated list of IROs is being used by ADVANTAGE. The list is reviewed on an ongoing basis by logging on to: <http://www.in.gov/doi/2990.htm>.

FAILURE TO ADHERE TO INTERNAL APPEALS PROCESS

The case of a plan or issuer that fails to strictly adhere to all the requirements of the internal appeals process with respect to a claim, the member is deemed to have exhausted the internal appeals process, regardless of whether the plan or issuer asserts that it substantially complied with these requirements or that any error it committed was de minimis. Accordingly, upon such a failure, the member may initiate an external review and pursue any available remedies under applicable law, such as judicial review.

A member is deemed to have exhausted a plan’s internal claims and appeals process if the plan “fails to adhere to all of the requirements” of the amended final rule, including strict compliance with the Department of Labor’s Claims Procedure Rule, unless:

- The violation is minimal.
- The violation does not cause (and is not likely to cause) prejudice or harm to the claimant; and the health plan demonstrates that the violation:
 - Was for good cause or due to matters beyond the plan’s control;

Policy Name: Commercial Members Grievances and Appeals for Fully Funded Lines of Business Policy Number: AG-001 Effective/Revision Date: 01/20/14; 07/15/14; 09/15/14; 03/30/15; 08/27/15; 06/01/16
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- Occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant; and
- Was not part of a pattern or practice of violations by the Plan.

If the plan believes a violation does not give the claimant cause to deem the internal process to be exhausted, the plan must provide the claimant a written explanation of the violation and a “specific description” of why it meets the above criteria, upon request.

CONTINUED COVERAGE WHILE GRIEVANCE/APEAL IN PROCESS

Members have continued coverage under their medical benefit pending the outcome of an internal appeal. This applies only to concurrent care decisions when an ongoing course of treatment has already been approved and does not apply to requests for extension of the course of treatment beyond the already approved period or number.

ADVANTAGE is only obligated to provide coverage up to end of the currently approved treatment or final determination, whichever comes first, subject to regulatory and contractual obligations. If the outcome of the appeal is in favor of ADVANTAGE, the Plan may seek reimbursement from the member for payments made for what has been determined to be an uncovered service, subject to regulatory and contractual obligations.

REPORTING TO THE INDIANA DEPARTMENT OF INSURANCE

<i>Responsible Party</i>	<i>Task(s)</i>
Appeals Specialist	1. When requested by Finance, on or before March 1 of each year, compile a report describing ADVANTAGE’s grievance process, the total number of grievances handled during the preceding calendar year, a compilation of the causes underlying the grievances and a summary of the final disposition of the grievances. 2. The report will be in a format consistent with the requirements of the Department of Insurance: <ul style="list-style-type: none"> • Tabular form • On eight and one-half (8 1/2) by eleven (11) inches paper • Includes a disk formulated for Microsoft Excel • Form follows 760 IAC 1-59-4, and 14 • Includes a list of participating providers under IC 27-13-8-2(a)(2) and a description of the grievance procedure under IC 27-8-2(a)(3) 3. Forward the report to Finance Manager for review and release to the Department of Insurance.
Finance	4. Review report for completeness, accuracy and format. 5. Deliver or send certified mail the grievance report, along with other required Plan reporting, to the Department of Insurance on or before March 1 of each calendar year.

RECORD MAINTENANCE

<i>Responsible Party</i>	<i>Task(s)</i>
Appeals Specialist	1. Records all information in the Application until final resolution. 2. Electronically maintain Grievance /Appeal files for a period of at least seven years. Each file includes, but is not limited to, the following: <ul style="list-style-type: none"> • Copy of the grievance/appeal and the date of filing

Policy Name: Commercial Members Grievances and Appeals for Fully Funded Lines of Business
Policy Number: AG-001
Effective/Revision Date: 01/20/14; 07/15/14; 09/15/14; 03/30/15; 08/27/15; 06/01/16

<i>Responsible Party</i>	<i>Task(s)</i>
	<ul style="list-style-type: none"> • Copies of all documentation, correspondence, consultations, or evidence submitted regarding the grievance • The dates and outcome/decisions on any grievance proceedings

AUDITING OF COMMERCIAL APPEALS & GRIEVANCES

<i>Responsible Party</i>	<i>Task(s)</i>
A&G Auditor (Medical Management Department Designee)	1. The A&G Auditor reviews a statistically valid random sampling of commercial fully funded & self-funded A&G files on a quarterly basis to determine compliance with National Committee for Quality Assurance (NCQA), Indiana Department of Insurance (IDOI), ERISA, and ACA regulations and standards.

ATTACHMENT A

ADVANTAGE Health Solutions, Inc. SM AUTHORIZATION REQUEST TO USE OR DISCLOSE Protected Health Information (updated 10/1/14)

****You may refuse to sign this authorization****

Purpose: This form is used to request an individual's authorization for ADVANTAGE to use or disclose protected health information only for the purpose(s) stated on this form. **This form may not be used to obtain authorization for use or disclosure of psychotherapy notes.**

No Conditions: This authorization is voluntary. We will not condition our treatment, payment, enrollment or eligibility for benefits on you giving this authorization.

Effect of Granting this Authorization: The protected health information described below may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

THIS AUTHORIZATION FORM MUST BE COMPLETED IN FULL IN ORDER FOR THE AUTHORIZATION TO BE VALID

Name: _____

Address: _____

Telephone #: _____

Subscriber Number: _____

Date of Birth: _____

Please describe what protected health information you are authorizing ADVANTAGE to Use or Disclose.

NOTE: You have the right to inspect and/or copy the Protected Health Information described above.

Please describe the purpose why you are authorizing ADVANTAGE to Use or Disclose your Protected Health Information described above.

Please confirm you are authorizing ADVANTAGE to Use or Disclose to others your Protected Health Information noted above:

- Yes
No

Please list the name or other specific identification of the person(s), or class of persons, authorized to receive the Protected Health Information or to whom you agree or object to ADVANTAGE's use or disclosure of PHI (indicate as applicable):

Expiration: This authorization will expire (complete one):

On ____/____/____

On occurrence of the following event (this event must relate to the individual or to the purpose of the use and/or disclosure being authorized):

--

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: **ADVANTAGE Health Solutions, Inc.**
 Attn: Compliance Department

Address: **9045 River Road, Suite 150**
 Indianapolis, IN 46240

Telephone: **1-877-901-2237 (Hearing Impaired 1-800-743-3333)** Fax: **317-536-3710**

SIGNATURE – YOU MAY REFUSE TO SIGN THIS AUTHORIZATION:

I, _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization that ADVANTAGE may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form for the purposes stated in this form.

I understand that, if the person or organizations I authorized to receive and/or use the protected health information described in this form are not health plans, covered health care providers, or health care clearinghouse subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Signature: _____ **Date:** _____
Printed Name: _____

If this authorization is signed by a **personal representative** on behalf of the individual, complete the following:

Personal Representative's Name: _____
Relationship to Individual: _____

YOU ARE ENTITLED TO RECEIVE A COPY OF THIS AUTHORIZATION AFTER SIGNATURE

ADVANTAGE Health Solutions, Inc. Initial Grievance (first level appeal)

REQUEST FOR INFORMATION

ADVANTAGE Health Solutions (ADVANTAGE) has received a grievance (first level appeal) regarding the following:

Member:

ID #:

Date of Service:

The basis of the grievance is as follows:

Please submit the following information within 5 calendar days for a pre-service issue or 10 calendar days for a post service issue (unless otherwise noted):

- Provider office notes
- Copy of denial letter or denial EOB
- Copy of claim (Actual claim copy – not screen prints from system)
- All Medical Director documentation
- All authorization/nurses/claim system notes
- All medical records received
- Form with applicable comments (please note that the decision will be rendered by ADVANTAGE and communicated to your network.

In addition, please submit the following:

All information should be sent via fax to: 317-536-3145

If the information cannot be faxed, you may mail the documentation to:

ADVANTAGE Health Solutions, Inc.
ATTN: Member Appeals Department
9045 river road, Suite 150
Indianapolis, IN 46240

Please contact the Appeals Department at 317-573-6689 or 1-888-806-1029 with any questions. Thank you for your assistance.

ATTACHMANT B-2



COMMERCIAL APPEALS AND GRIEVANCES TRACKING

Information contained in this system is proprietary and confidential and not to be used outside of this business process.

Commercial Appeal - Level 1

[Save](#) [Create Level 2 Appeal](#) [Appeals and Grievances List](#) [Delete Appeal](#)

Appeal ID	<input type="text"/>	Owner	<input type="text"/>
Appeal Reason	<input type="text"/>	Assigned To	<input type="text"/> <input type="checkbox"/> Send
IDOI Code	<input type="text"/>	Email	<input type="text"/>
Clinical	<input type="checkbox"/>		<input type="button" value="Remove"/>
Issue	<input type="text"/>	Email Comments	<input type="text"/>
Type of Appeal	<input type="text"/>	Weekly Status	<input type="text"/>
Expedited	<input type="checkbox"/>		
Extension	<input type="checkbox"/>		
Appeal Status	<input type="text" value="Active"/>	Documents	
Member Name	First: <input type="text"/> Middle: <input type="text"/> Last: <input type="text"/>	Comments Level 1	<input type="text"/>
Address:	Address1: <input type="text"/>		
Phone:	(<input type="text"/>) <input type="text"/> - <input type="text"/> Ext: <input type="text"/>		
Member Number	<input type="text"/>		
Member Effective Date	<input type="text"/> <input type="button" value="Calendar"/>		
Employer	<input type="text"/>		
Product	<input type="text"/>		

PHO	<input type="text"/>
Referring Provider Name	First: <input type="text"/> Last: <input type="text"/>
Provider of Service Name	First: <input type="text"/> Last: <input type="text"/>
Date of Service (DOS)	<input type="text"/> 
Date of Denial (DOD)	<input type="text"/> 
Date Received	<input type="text"/> 
Date Acknowledged	<input type="text"/> 
Due Date	
Extension Due Date	
Level 1 Decision	<input type="text"/>
Decision Reason Code	<input type="text"/>
A or G	<input type="text"/>
A/G Amount	\$ <input type="text"/>
Date Closed	<input type="text"/> 
Days to Resolve	
Last Update	

Version 2.0

ATTACHMENT C

Patient Name: _____

Scanned Pages: _____

ID#: _____

DOS: _____

A & G FILE CHECK LIST

- Make sure there is not a previous appeal on the issue at hand
- Load into A&G Data Base
- Send Acknowledgement letter with appeal rights, put copy in file
- Complete Intake form
- Original denial letter, verify that the letter is correct
- Medical records used in the denial/fax to _____
- Document call tracking
- Panel sign off sheet and email confirming everyone's decision
- Decision letter (ensure correct 2nd level adverse determination letters are used)
- Copy of appeals rights with every acknowledgement and adverse determination letter
- Titles and specialties of all panel participants to be on all decision letters
- Other: _____

JL 3/4/14

ATTACHMENT D
(Acknowledgment of Request for Grievance)

(Date)
(Name
Address
City, State Zip)

Re: (reason for grievance)

Dear (Mr. / Ms. Member Name):

We are in receipt of your grievance regarding (reason for the grievance). We received the grievance on (date grievance received).

ADVANTAGE Health Solutions, Inc.SM (ADVANTAGE) will review your grievance according to the following timeframes:

- Pre-service grievances:

A pre-service grievance or appeal is a request to change an adverse determination for care or services in advance of the member obtaining the care or services. ADVANTAGE resolves pre-service grievances or appeals within 15 calendar days from receipt of the request at each level of review (first and second levels).

- Post-service grievances:

A post-service grievance or appeal is a request to change an adverse determination for care or services that have already been received by the member. ADVANTAGE resolves Level 1 post-service grievances within 20 business days after the grievance is filed. If we are unable to make a decision regarding the grievance within the twenty (20) day period due to circumstances beyond our control, then we shall: (1) notify you in writing advising of the reason for the delay before the twentieth business day, and (2) issue a written decision within an additional ten business days.

- Expedited grievances:

ADVANTAGE offers the member an expedited appeal for any urgent care request. Urgent care involves conditions which:

“Could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, based on a prudent layperson’s judgment or

In the opinion of a physician with knowledge of the member’s medical condition would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.”

ADVANTAGE must make the expedited grievance or appeal decision as expeditiously as the medical condition requires, but no later than 72 hours after the request. An expedited review begins when a member, a representative of the member or a practitioner acting on behalf of the member requests an expedited appeal either verbally, by facsimile, in writing or by any means of electronic communication. ADVANTAGE grants an expedited review to all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from the facility.

Please see the enclosed Notice of Appeal Rights for further details.

Should you have any questions in the interim, please feel free to contact me at (317) 573-6689, toll-free at (888) 806-1029 or at 9045 River Road, Suite 150, Indianapolis, IN 46240.

Sincerely,

[Name]
[Title]

ATTACHMENT E

Notice of Appeals Rights

GRIEVANCES – LEVEL 1

If you need assistance understanding this notice or our decision to deny you a service or coverage, you are encouraged to contact the Appeals Department at ADVANTAGE with any questions or grievances. You may request a Level 1 grievance within 180 calendar days from the date of the initial notice of the adverse decision. **Please address your request for a grievance to:**

**Member Appeals Department
ADVANTAGE Health Solutions, Inc.SM
9045 River Road, Suite 150
Indianapolis, IN 46240**

Or you may call us, toll-free, at 1-888-806-1029 between the hours of 8 am through 5 pm, Monday through Friday, EST, excluding holidays. You may also call the number on the back of your identification card for assistance in filing a grievance. Please include the following information in your correspondence, or have this information ready when telephoning:

Subscriber's Name
Patient's Name
Subscriber's Health Plan (HP) Number
The Nature of the Grievance

When the grievance is received, it will be recorded in the Application so that it can be tracked and resolved. A confidential file will be opened and maintained throughout the case until resolution, documenting the substance of the grievance and actions taken. You have the right to submit written comments, documents, or other information relating to the grievance.

YOU MUST INCLUDE YOUR MEMBER IDENTIFICATION WHEN SUBMITTING A GRIEVANCE

You shall be mailed an acknowledgment letter of your grievance within three (3) business days after receipt of your grievance request.

Grievances will be resolved according to the following time frames:

- **Pre-service grievances:** A pre-service Level 1 grievance or appeal is a request to change an adverse determination for care or services in advance of the member obtaining the care or services. ADVANTAGE resolves pre-service grievances within 15 calendar days from receipt of the request at each level of review (Level 1 and Level 2).
- **Post-service grievances:** A post-service Level 1 grievance (or appeal) is a request to change an adverse determination for care or services that have already been received by the member. ADVANTAGE resolves post-service grievances within 20 business days after the grievance is filed. If we are unable to make a decision regarding the grievance within the twenty (20) day period due to circumstances beyond our control, then we shall: (1) notify you in writing advising of the reason for the delay before the 20th business day, and (2) issue a written decision within an additional 10 business days.

APPEALS LEVEL 2

If the Level 1 grievance was not resolved to your satisfaction, you may appeal within 180 calendar days from the grievance decision by writing to the Appeals Department. **Please address your request for a Level 2 appeal to:**

**Member Appeals Department
ADVANTAGE Health Solutions, Inc.SM
9045 River Road, Suite 150
Indianapolis, IN 46240**

or you may call us, toll-free, at 888-806-1029 between the hours of 8 am through 5 pm, Monday through Friday, EST, excluding holidays. You may also call the number on the back of your identification card for assistance in filing an appeal. Please include the following information in your correspondence, or have this information ready when telephoning:

Subscriber's Name
Patient's Name
Subscriber's Health Plan (HP) Number
The Date of the Original Grievance
The Nature of the Grievance

You shall be mailed an acknowledgment of your request for a review by the Level 2 Appeals Panel within three (3) business days of receipt of your request.

The appeal will be reviewed by the Level 2 Appeals Panel which, in the case of an appeal regarding medical care or treatment, will be composed of one or more individuals who have knowledge of the medical condition, procedure, or treatment at issue. The individual(s) will be in the same licensed profession as the provider who proposed, refused, or delivered the health care procedure, treatment, or service in question and who was not involved in the matter giving rise to the appeal.

If you wish to appear before the Level 2 Appeals Panel, you should make that request in the letter or telephone call requesting the appeal. You may also communicate with the Panel through other appropriate means if you are unable to appear in person. The Level 2 Appeals Panel will meet during regular business hours (Mon-Fri 8AM-5PM, EST). You may submit written comments, documents or other information relating to the appeal.

Appeals will be resolved according to the following time frames:

- **Pre-service appeals:** A pre-service Level 2 appeal is a request to change an adverse determination for care or services in advance of the member obtaining the care or services. ADVANTAGE resolves pre-service appeals within 15 calendar days from receipt of the request at each level of review (Level 1 and Level 2).
- **Post-service appeals:** A post-service Level 2 appeal is a request to change an adverse determination for care or services that have already been received by the member. ADVANTAGE resolves post-service Level 2 appeals within 30 calendar days from receipt of the request for a Level 2 appeal.

ASSISTANCE UNDERSTANDING THIS NOTICE

Contact us at 1-888-806-1029 if you need assistance understanding this notice or our decision to deny you a service or coverage. If you have a hearing impairment you may use TDD services at 800-728-1777. If you have limited use and/or understanding of English, ADVANTAGE will provide interpreter services to you or your representative through a third party translation service at no charge to the member.

EXPEDITED GRIEVANCES AND APPEALS

Expedited grievances and appeals:

ADVANTAGE offers the member an expedited appeal for any urgent care request that meets the definition of urgent under the law. A claim involving urgent care is a claim for medical care or treatment with respect to which application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, based on a prudent layperson's judgment or in the opinion of a physician with knowledge of the member's medical condition would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request including all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from the facility

An expedited review begins when a member, a representative of the member, or a practitioner acting on behalf of the member requests an expedited appeal either verbally, by facsimile, in writing or by any means of electronic communication. .

ADVANTAGE must make the expedited grievance or appeal decision as expeditiously as the medical condition requires, but no later than 72 hours after the request, unless the member fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan or health insurance coverage. The member may also begin an expedited external review at the same time as the expedited internal appeals process if this is an urgent care situation and if the case is subject to external review.

EXTERNAL REVIEW

If you are dissatisfied with our decision of the second-level review, you have the option for certain types of claims of requesting an external review by an Independent Review Organization certified by the Indiana Department of Insurance. If you choose to request an external review of your appeal, send a notice in writing within 180 calendar days of receipt of the second-level decision. Per Indiana Code IC 27-13-10.1-1, you may request an external review for the resolution of grievances regarding the following:

- (1) The following determinations made by the health maintenance organization or an agent of the health maintenance organization regarding service proposed by the treating physician:
 1. an adverse utilization determination
 2. an adverse determination of medical necessity: or
 3. a determination that a proposed service is experimental or investigational made by a health maintenance organization or an agent of a health maintenance organization regarding a service proposed by a treating physician.
- (2) The health maintenance organization's decision to rescind an individual contract or a group contract.

Please address your request for an external review to:

**Appeals Department
ADVANTAGE Health Solutions, Inc.SM
9045 River Road, Suite 150
Indianapolis, IN 46240**

Under the external review process, the Independent Review Organization will make a determination within 15 business days after the external appeal is filed, or for expedited requests, within 72 hours after the external appeal is filed. You may provide any requested information to the Independent Review Organization or authorize our release of information to the Independent Review Organization. You may also submit any additional information relevant to the claim.

The Independent Review Organization will review our decision and provide a written determination. If this organization decides to overturn our decision, we will provide coverage or payment for your health care item or service. You are not required to bear any costs, or filing fees associated with the Independent Review Organization review.

You may not file more than one external review request for each grievance.

The request may be expedited for an appeal related to an illness, a disease, a condition, an injury or a disability that would seriously jeopardize the member's life or health or ability to reach and maintain maximum function.

The member may also begin an expedited external review at the same time as the expedited internal appeals process if this is an urgent care situation and if the case is subject to external review.

If you have the right to external review under Medicare, you may not request external review through the plan.

RIGHT TO RECEIVE INFORMATION

For any level of appeal, you are entitled to receive, upon request, reasonable access and copies of all documents relevant to the grievance or appeal. Relevant documents include documents or records relied upon in making the decision and documents and records submitted in the course of making the decision. You are entitled to receive, upon request, a copy of the actual benefit provision, guideline, protocol or similar criterion on which the decision was based. You have the right to have billing and diagnosis codes sent to you, as well. You may request copies of this information by contacting us at 1-888-806-1029. You are not required to bear any costs associated with these requests.

You will be provided, free of charge, with any new or additional evidence considered, relied upon or generated in connection with your claim. In addition, before you receive an adverse benefit determination or review based on a new or additional rationale, you will be provided, free of charge, with the rationale.

DESIGNATING A REPRESENTATIVE

A member may designate a representative to file a grievance for the member and to represent the member in the resolution and/or appeal of any grievance or appeal including external review. You may need to sign an authorization release in order to allow us to discuss your situation with your representative.

QUESTIONS AND CONCERNS

Your satisfaction is very important to us. We have set up the Appeals & Grievance Procedure to help ensure that any problem with any aspect of this Plan is addressed in a fair and timely manner. We fully expect to provide a fair settlement for every valid grievance in a timely fashion. However, if you feel that you (a) you need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, IN 46204-2787

Consumer Hotline: (800) 622-4461 or
Indianapolis area: (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi

Other Resources to Help You:

For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

You may also have remedies available to you through The Department of Labor under 502(a) of the ERISA Act.

ATTACHMENT F (REVERSAL)

Date

To

Re:

Dear (*name*):

This letter is in response to the grievance you filed regarding the denial of coverage for XXXXXXXX (*explanation*). We received the grievance on (*date*).

[List panel members by title] reviewed the following information:

(*information reviewed*)

We have made the following decision regarding your grievance:

(*favorable decision - include reason for grievance, benefit provisions, guidelines, protocol, criteria, contract information, any member education required*)

ADVANTAGE Health Solutions, Inc.SM (ADVANTAGE) may elect to offer via grievance or appeal review benefits for services, pursuant to an approved alternative treatment plan for a member. Alternative benefits are provided at the sole discretion of ADVANTAGE, and only when and for so long as ADVANTAGE determines that alternative services are medically necessary.

If ADVANTAGE elects to provide alternative benefits for a patient in one instance, it will not be obligated to provide the same or similar benefits for other patients in another instance, nor will it be construed as a waiver of ADVANTAGE's right to administer the benefits thereafter in strict accordance with its express terms. Further, if ADVANTAGE elects to provide alternative benefits for a patient, it will not obligate itself to provide the same benefits for the same patient without prior authorization from ADVANTAGE.

If you have any further questions regarding this matter, please feel free to contact me at (317) 573-6689, toll-free at (888) 806-1029 (TDD 800-782-1777), or at the address below. I will be glad to assist you.

Sincerely,

[Name]

[Title]

ATTACHMENT F-1 (Uphold denial of coverage – Level 1)

Date of Notice

Member Name and Address

Appeals Department
ADVANTAGE Health Solutions, Inc.SM
9045 River Road, Suite 150
Indianapolis, IN 46240

Toll-free (888) 806-1029 or (317) 573-6689
TDD (800) 782-1777
Fax (317) 587-8429
www.advantageplan.com

This document contains important information that you should retain for your records.

This document serves as notice of an adverse benefit determination. We have declined to provide benefits, in whole or in part, for the requested treatment or service described below. If you think this determination was made in error, you have the right to appeal.

Case Details:

Patient Name:	ID Number:
Address: (street, county, state, zip)	
Claim #:	Date of Service:
Provider:	

Reason for Denial (in whole or in part):

Amt. Charged	Allowed Amt.	Other Insurance	Deductible	Co-pay	Coinsurance	Other Amts. Not Covered	Amt. Paid
YTD Credit toward Deductible:			YTD Credit toward Out-of-Pocket Maximum:				
Description of service:			Denial Codes:				

Background Information:

We have completed our investigation of your grievance regarding the denial of coverage for XXXXXXXXX. We received the grievance on XXXXXXXXX.

The grievance panel, which included, [XXXXXXXXXXXXXXXXXXXXXXXXXXXX -MUST INCLUDE SPECIALTY OF PHYSICIAN] reviewed the following information

Comments and documents received from member and plan documents.

Explanation of Basis for Determination:

[If the claim is denied (in whole or in part) and there is more explanation for the basis of the denial, such as the definition of a plan or policy term, include that information here. – This replaces “Reason for Upholding Denial and Internal Adverse Benefit Determination – combine information to member into this one category]

[Insert if Pre-Service] [Only our payment decision for the requested treatment is affected by the medical necessity determination. The final decision to receive services is yours to make jointly with your provider. You may choose to assume responsibility for services rendered]

If you have any further questions regarding this matter, please feel free to contact me at the above-mentioned number.

Sincerely,

[Name]

[Title]

Enclosure: Notice of Appeal Rights [Attach Attachment E]

Important Information about Your Appeal Rights

What if I need help understanding this denial?

Contact us at (1-888)-806-1029 (for hearing impaired, TDD (1-800-728-1777) if you need assistance understanding this notice or our decision to deny you a service or coverage. If you have limited use and/or understanding of English, ADVANTAGE will provide interpreter services to you or your representative through a third party translation service. Interpreter services are available at no charge to the member.

What if I don't agree with this decision? You have a right to appeal any decision not to provide or pay for an item or service (in whole or in part).

How do I file an appeal? To request a second-level appeal, you must write or call ADVANTAGE Health Solutions, Inc.SM within **180** calendar days of the date of this letter. A complete description of the second-level Appeals process is enclosed for your reference. See attached *Notice of Appeals Rights for contact information*. You may also use the attached *Request for Second Level Appeal* form.

See also the "Other resources to help you" section of this form for assistance filing a request for an appeal.

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will generally be conducted within 72 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by following the instructions in the attached *Notice of Appeal Rights*. If the appeal meets the criteria for expedited appeal, you may request an expedited external review at the same time as the expedited internal appeals process if this is an urgent care situation and if the case is subject to external review.

Who may file an appeal? You or someone you name to act for you (your authorized representative) may file an appeal. You will have to sign an Authorization release form in order to allow us to discuss your situation with your representative. Please contact us at (888)-806-1029 to request the authorization form.

Can I provide additional information about my claim? Yes, you may supply additional information you feel will substantiate your request for re-evaluation by the second-level appeals panel.

Contact the Appeals & Grievance department at 888-806-1029 for instructions on submitting additional information.

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge). If you think a coding error may have caused this claim to be denied, you have the right to have billing and diagnosis codes sent to you, as well. You can request copies of this information by contacting us at our Member Services department (1-800-553-8933) for instructions on obtaining claim information. You may contact our Appeals & Grievances department (1-888-806-1029) to request copies of your appeal file.

What happens next? If you appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Other resources to help you: For questions about your rights, this notice, or for assistance, you can contact:

The Employee Benefits Security Administration at 1-866-444-EBSA (3272) and/or:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, IN 46204-2787

Consumer Hotline: (800) 622-4461 or
Indianapolis area: (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi

You may also have remedies available to you through The Department of Labor under 502(a) of the ERISA Act.

Important Information about Your Appeal Rights

ADVANTAGE Health Solutions, Inc.

REQUEST FOR SECOND-LEVEL APPEAL

Name of person filing for appeal:

(Please print name) _____

Check one:

(Subscriber/Member) Parent/Guardian of Minor Dependent Authorized Representative

Contact information of person filing request for external review (if different from subscriber/member)

Address: _____

Daytime phone: _____

If the person filing the request for an appeal is other than the subscriber/member, **member must indicate authorization by a signed and dated HIPAA Authorization form or a Durable Power of Attorney (POA) that includes reference to healthcare language.** Contact 1- 888-806-1029 to obtain a copy of the Authorization form.

Do you have a current signed HIPAA Authorization Form or POA on file with ADVANTAGE?

Yes No Not applicable for this request

Are you requesting an urgent review? Yes No

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician’s letter, bills, medical records, or other documents to support your claim):

Signature of subscriber/member: _____ Date: _____

Signature of Authorized Representative (if applicable): _____ Date: _____

Send this completed form, along with any additional documentation, and your denial notice to:

Member Appeals Department
ADVANTAGE Health Solutions, Inc.
9045 River Road, Suite 150
Indianapolis, IN 46240

Be certain to keep copies of this form, your denial notice, and all documents and correspondence related to this claim

ATTACHMENT G (Acknowledgment of 2nd Level Appeal Request)

Date

Name
Address
City, St Zip

I. RE: NOTICE OF FORMAL APPEALS PANEL HEARING

Dear XXXXXXX,

On XXXXXXXX we received your request for re-evaluation by the Appeals Panel of your grievance regarding XXXXX services provided to XXX on XXXXX. We are required to respond to your appeal within the following time frames:

- Pre-service grievances:

A pre-service grievance or appeal is a request to change an adverse determination for care or services in advance of the member obtaining the care or services. ADVANTAGE resolves pre-service grievances or appeals within 15 calendar days from receipt of the request at each level of review (first and second levels).

- Post-service appeals:

A post-service grievance or appeal is a request to change an adverse determination for care or services that have already been received by the member. ADVANTAGE resolves post-service appeals within 30 calendar days from receipt of the request.

Your appeal has been scheduled as follows:

Date: XXXXX
Time: XXXXX
Location: ADVANTAGE Health Solutions, Inc.SM
9045 River Road, Suite 150
Indianapolis, IN 46240

A full review of your case will be presented to the Appeals Panel at this meeting. Should you wish to participate via conference call, please follow the below steps:

At XXXX, please dial 1-888-527-7995. Listen to the instructions and at the end of the message please enter pass code 1060325 followed by the # sign. You will then be connected to the appeals panel. Please contact me at 317-573-6689 or 888-806-1029 if you plan to participate.

Should you wish to present your case to the Appeals Panel in person or by other means, please contact me to arrange to do so. You may also submit written comments, documents or other information relating to the appeal.

The Appeals Panel meeting is designed to be a fair and informal session that provides an opportunity for the presentation of your interpretation of the facts and concerns surrounding your case to individuals who were not involved in either the initial adverse determination or the initial grievance outcome.

The Appeals Panel meeting will be limited in scope to the re-review of the grievance you filed. If there are other issues you wish to pursue, these issues should be directed through the formal grievance process.

To protect the interests of all involved parties, we do not permit recording of the Appeals Panel meeting by any device.

The resolution of your grievance appeal will not be revealed during the Panel meeting. You will receive written notification of the outcome of the panel's review.

Should you have any questions regarding the Appeals Panel's re-evaluation of your case, please contact me at the above-mentioned telephone number.

Sincerely,

[Name].

[Title]

Enclosure: Notice of Appeal Rights [attach Attachment E]

ATTACHMENT H (Upheld Level 2 Appeal)

Date of Notice

Member Name and Address

Appeals Department
 ADVANTAGE Health Solutions, Inc.SM
 9045 River Road, Suite 150
 Indianapolis, IN 46240

Toll-free (888) 806-1029 or (317) 573-6689
 TDD (800) 782-1777
 Fax (317) 587-8429
www.advantageplan.com

This document contains important information that you should retain for your records.

This document serves as notice of a final internal adverse benefit determination. We have declined to provide benefits, in whole or in part, for the requested treatment or service described below. If you think this determination was made in error, you may have the right to appeal. Please see the attached **Important Information about Your Rights to External Review**.

Internal Appeal Case Details:

Patient Name:				ID Number:			
Address: (street, county, state, zip)							
Claim #:				Date of Service:			
Provider:							
Reason for Upholding Denial (in whole or in part):							
Amt. Charged	Allowed Amt.	Other Insurance	Deductible	Co-pay	Coinsurance	Other Amts. Not Covered	Amt. Paid
YTD Credit toward Deductible:				YTD Credit toward Out-of-Pocket Maximum:			
Description of Service:				Denial Codes:			

Background Information:

On XXXXXX, we received your request for re-evaluation by the Appeals Panel of your grievance regarding the denial of coverage for XXXX on XXXXXX. We have completed our investigation of your appeal.

The appeals panel, which included [Insert members of the appeals/grievance panel by title and physician specialty], reviewed the following information

[Insert documentation and any member/provider comments used in decision]

Final Internal Adverse Benefit Determination: *[State that adverse benefit determination has been upheld. List all documents and statements that were reviewed to make this final internal adverse benefit determination.]*

Findings: *[Discuss the reason or reasons for the final internal adverse benefit determination. Formerly Reason for Upholding Denial section.]*

Sincerely,

[Appeals Specialist Name]

[Title]

Important Information about Your Rights to External Review

What if I need help understanding this denial?

Contact us at (888)-806-1029 (for hearing impaired, TDD (800)-728-1777) if you need assistance understanding this notice or our decision to deny you a service or coverage. If you have limited use and/or understanding of English, ADVANTAGE will provide interpreter services to you or your representative through a third party translation service. Interpreter services are available at no charge to the member.

What if I don't agree with this decision? For certain types of claims, you are entitled to request an independent, external review of our decision. Contact (888)-806-1029 with any questions on your rights to external review. If your claim is not eligible for independent external review but you still disagree with the denial, your state insurance regulator may be able to help to resolve the dispute. See the "Other resources section" of this form for help filing a request for external review.

Per Indiana Code IC 27-13-10.1-1, you may request an external review for the resolution of grievances regarding the following:

- (1) The following determinations made by the health maintenance organization or an agent of the health maintenance organization regarding service proposed by the treating physician:
 1. an adverse utilization determination
 2. an adverse determination of medical necessity; or
 3. a determination that a proposed service is experimental or investigational made by a health maintenance organization or an agent of a health maintenance organization regarding a service proposed by a treating physician.
- (2) The health maintenance organization's decision to rescind an individual contract or a group contract.

How do I file a request for external review?

Complete the form on page 4, make a copy, and send this document to:

Member Appeals Department
ADVANTAGE Health Solutions, Inc.
9045 River Road, Suite 150
Indianapolis, IN 46240

You may request an external review within 180 calendar days of the date of this notice.

See also the "Other resources to help you" section of this form for assistance filing a request for external review.

What if my situation is urgent? If your situation meets

the definition of urgent under the law, the external review of your claim will be conducted as expeditiously as possible. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe your situation is urgent, you may request an expedited external review by calling us at (888)-806-1029.

Who may file a request for external review? You or someone you name to act for you (your authorized representative) may file a request for external review. You will have to sign an Authorization release form in order to allow us to discuss your situation with your representative. Please contact us at (888)-806-1029 to request the authorization form.

Can I provide additional information about my claim? Yes, once your external review is initiated, you will receive instructions on how to supply additional information.

Can I request copies of information relevant to my claim? Yes, you may request copies of your appeal file (free of charge) by contacting us at (888)-806-1029.

What happens next? If you request an external review, an independent organization will review our decision and provide you with a written determination. If this organization decides to overturn our decision, we will provide coverage or payment for your health care item or service.

Other resources to help you: For questions about your rights, this notice, or for assistance, you can contact:

The Employee Benefits Security Administration at 1-866-444-EBSA (3272) and/or:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, IN 46204-2787

Consumer Hotline: (800) 622-4461 or
Indianapolis area: (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi

You may also have remedies available to you through The Department of Labor under 502(a) of the ERISA Act

Important Information about Your Rights to External Review

ADVANTAGE Health Solutions, Inc.

REQUEST FOR EXTERNAL REVIEW

Name of person filing request for external review:

(Please print name) _____

Check one:

(Subscriber/Member) Parent/Guardian of Minor Dependent Authorized Representative

Contact information of person filing request for external review (if different from subscriber/member)

Address:

Daytime phone: _____

If the person filing the request for external review is other than the subscriber/member, **member must indicate authorization by a signed and dated HIPAA Authorization form or a Durable Power of Attorney (POA) that includes reference to healthcare language.** Contact 888-806-1029 to obtain a copy of the Authorization form.

Do you have a current signed HIPAA Authorization Form or POA on file with ADVANTAGE?

Yes No Not applicable for this request

Are you requesting an urgent review? Yes No

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim):

Signature of subscriber/member: _____ Date: _____

Signature of Authorized Representative (if applicable): _____ Date: _____

Send this completed form, along with any additional documentation, and your denial notice to:

Member Appeals Department
ADVANTAGE Health Solutions, Inc.
9045 River Road, Suite 150
Indianapolis, IN 46240

Be certain to keep copies of this form, your denial notice, and all documents and correspondence related to this claim.

ATTACHMENT I – Acknowledgment of Request for Eligible External Review

Date

Name and Address

Re: Request for external appeal review for denial of coverage of [insert issue]

Dear XXXX,

We are in receipt of your request for an external appeal review regarding the denial of coverage for services XXXXXXXX on XXXXXXXX. We received the request on XXXXXXXX.

We have reviewed your request. Your appeal is eligible for an external review by an Independent Review Organization (IRO) approved by the State of Indiana. The IRO to be used in your review is:

[Insert IRO name, address, and phone number contact information should the member want to send additional information]

You may submit in writing additional information related to the appeal to the IRO within five (5) business days of this notification.

EXTERNAL REVIEW

Per Indiana Code IC 27-13-10.1-1, you may request an external review for the resolution of grievances regarding the following:

- (1) The following determinations made by the health maintenance organization or an agent of the health maintenance organization regarding service proposed by the treating physician:
 - an adverse utilization determination
 - an adverse determination of medical necessity; or
 - a determination that a proposed service is experimental or investigational made by a health maintenance organization or an agent of a health maintenance organization regarding a service proposed by a treating physician.

- (2) The health maintenance organization's decision to rescind an individual contract or a group contract.

Under the external review process, the Independent Review Organization will make a determination within 15 business days of your request, or for expedited requests, within 72 hours of receipt of your request. You may provide any requested information to the Independent Review Organization or authorize our release of information to the Independent Review Organization. You may also submit any additional information relevant to the claim.

The Independent Review Organization will review our decision and provide a written determination. If this organization decides to overturn our decision, we will provide coverage or payment for your health care item or service. You are not required to bear any costs, or filing fees associated with the Independent Review Organization review.

You may not file more than one external review request for each grievance.

If you have the right to external review under Medicare, you may not request external review through the plan.

Should you have any questions in the interim, please feel free to contact me at (317) 573-6689, toll-free at (888) 806-1029 or at 9045 River Road, Suite 150, Indianapolis, IN 46240.

Sincerely,

[Name]

[Title]

Enclosure: Notice of Appeal Rights (attach Attachment E)

ATTACHMENT J- Acknowledgment of Request for External Review (Denied)

Date

Name and Address

Re: Request for external appeal review for denial of coverage of [insert issue]

Dear XXXX,

We are in receipt of your request for an external appeal review regarding the denial of coverage for services XXXXXXXX on XXXXXXXX. We received the request on XXXXXXXX.

We have reviewed your request. Your appeal is not eligible for an external review by an Independent Review Organization (IRO). The basis of your appeal does not meet the below listed criteria for an external review.

EXTERNAL REVIEW

Per Indiana Code IC 27-13-10.1-1, you may request an external review for the resolution of grievances regarding the following:

- (1) The following determinations made by the health maintenance organization or an agent of the health maintenance organization regarding service proposed by the treating physician:
 - an adverse utilization determination
 - an adverse determination of medical necessity; or
 - a determination that a proposed service is experimental or investigational made by a health maintenance organization or an agent of a health maintenance organization regarding a service proposed by a treating physician.

- (2) The health maintenance organization's decision to rescind an individual contract or a group contract.

Should you have any questions in the interim, please feel free to contact me at (317) 573-6689, toll-free at (888) 806-1029 or at 9045 River Road, Suite 150, Indianapolis, IN 46240.

Sincerely,

[Name]

[Title]