



POLICY / PROCEDURE		
Effective Date	Last Review / Revision Date	Next Annual Review Date
11/2014	09/2015	09/2016
Attachments		
<input type="checkbox"/> Yes		<input checked="" type="checkbox"/> No
Department	Process Owner	Policy Inventory No.
Customer Advocacy Operations	Melissa Mougey	SO-27-M

Product line:	Corresponding State:
Health Insurance Marketplace	
Health Insurance Marketplace	Indiana

A. POLICY / PROCEDURE TITLE

Customer Advocacy Operations - Member Grievance Process

B. DESCRIPTION / PURPOSE

To define a process for Members to request resolution of Grievances that are unrelated to Plan benefits and benefit denials.

C. DEFINITIONS

1. **Adverse Benefit Determination** - A decision by the Plan to deny, reduce, or terminate a requested health care service or benefit, in whole or in part, including all of the following decisions:
 - a. A determination that the health care service or benefit does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments;
 - b. A determination that an individual is not eligible for benefits under the Plan;
 - c. A determination that a health care service is not a covered service under the Plan;
 - d. The imposition of an exclusion or other limitation on benefits that would otherwise be covered;
 - e. A determination not to issue and individual coverage; or
 - f. A determination to rescind an individual's coverage under the Plan.
2. **Authorized Member Representative or Authorized Representative** –
 - a. A person to whom a Covered Person has given express written consent to represent the Covered Person in an external review.
 - b. A person authorized by law to provide substituted consent for a Covered Person.
 - c. If the Covered Person is unable to provide consent, a family member of the Covered Person or the Covered Person's treating health care professional.
3. **Covered Person (Member)** – An individual who is enrolled under the Plan.
4. **Customer Advocate (CA)** – The CA is the person responsible for the resolution of Member inquiries. During the Member interaction if the issue requires additional actions to be taken it is the CA's responsibility to route all Member Grievances to the Grievance and Appeals Department.

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5. **Grievance (Complaint)** – Any expression of dissatisfaction by a Covered Person or the Covered Person's Authorized Representative regarding:
 - a. Availability, delivery, appropriateness, or quality of Health Care Services; or
 - b. Handling or payment of claims for Health Care Services; or
 - c. Matters pertaining to the Plan's contractual relationship; or
 - d. The decision to rescind a Covered Person's coverage under the Plan.
6. **Grievance and Appeals Specialist (GAS)** – The Grievance and Appeals Specialist is a person who works the Grievance issue filed by the Member or on the Member's behalf by investigating the Member's Grievance through Member, provider, and/or additional business units to determine a satisfactory means of resolution.
7. **IDI** – State of Indiana Department of Insurance.
8. **Plan** – CareSource, a Qualified Health Plan issuer.
9. **Quality Improvement (QI) Specialist** – Person responsible for investigating all quality of care Complaints.
10. **Resolution** – A final decision made by the Plan related to the Grievance and communicated to the Member.

D. POLICY

It is the policy of CareSource to provide a Grievance system that shows how CareSource allows Members or their authorized representatives a forum for expressing a Grievance.

E. PROCEDURE

Issues related to Adverse Benefit Determinations will be addressed in accordance with the Adverse Benefit Determination Appeal Process Policy. During the Member interaction, if the issue requires additional actions to be taken it is the CA's responsibility to route all Member Grievances to the Grievance and Appeals Department.

1. Members can submit a Grievance to the Plan in one (1) of three (3) methods:
 - a. In writing, by sending a letter to the following address:
CareSource Just4Me
Attn: Member Appeals
PO Box 1947
Dayton, OH 45401;
 - b. By calling Member Services at 1-877-806-9284; or
 - c. By arranging to meet with the Plan in person.
2. The Plan will acknowledge all Grievances submitted by the Member or the Member's Authorized Representative, orally or in writing, within three (3) business days of our receipt of the Grievance.
3. Grievances related to quality of care issues will be forwarded to the Quality Improvement (QI) Clinical Grievance Department within one (1) business day for investigation and follow-up by qualified clinical personnel.

Note: All Member-facing departments have been trained on Grievance identification and the appropriate process to communicate Member Grievances to the Customer Advocacy Grievance Department. Such training includes process for submission of urgent Grievances to the QI Clinical Grievance Department.

4. CareSource will give Members at no cost all reasonable assistance in filing a Grievance, including but not limited to:

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- a. Explaining our process to be followed in resolving the Grievance.
 - b. Completing forms and taking other procedural steps as outlined in this policy.
 - c. Providing oral interpreter and oral translation services, sign language assistance, and access to our Grievance system through a toll-free number with text telephone yoke (TTY) and interpreter capability.
5. Documentation will include the substance of the Member's Grievance and actions taken to resolve the Grievance.
 6. The Plan will investigate, resolve, and notify the Member of the disposition of their Grievance in writing within twenty (20) business days upon receipt of the Grievance to the Plan.
 7. If unable to resolve a Grievance within the twenty (20) business day period, the Plan will notify the member in writing of the reason for the delay before the end of the twenty (20) business day period, and will notify the member in writing within an additional ten (10) business days of the Plan's resolution.
 8. If a Member is dissatisfied with a Grievance resolution, the Member may contact CareSource Customer Care to discuss their Grievance. If the Member is unsatisfied with the Plan's decision regarding their Grievance, the Member or the Member's Authorized Representative may submit an Appeal, orally or in writing, within one hundred eighty (180) days of receiving notice of the Plan's decision. The Plan will acknowledge receipt of the Member's Appeal within three (3) business days after receiving the Appeal request.
 9. The Plan will not under any circumstances delegate the Member process to another entity.
 10. The Plan will maintain records of all Grievances including documentation regarding the resolution of Grievances for a period of ten (10) years.
 11. The Customer Advocacy Department will be responsible for the logging and reporting of Grievances and assuring that the Grievance system meets IDI requirements.
 12. The Plan will submit information regarding Grievance activity as directed by IDI.
 13. All Plan departments will ensure compliance with Grievance guidelines and timeframes within their respective areas. They will also maintain departmental procedures for corrective action.

APPEAL OF A GRIEVANCE RESOLUTION

1. Members have 180 days from receipt of the Grievance resolution notice to file the appeal of a Grievance resolution.
2. Member may file an appeal of a Grievance resolution orally or in writing.
3. CareSource will provide language service to members if requested during the appeal process
4. CareSource will send an acknowledgement letter to the member within 3 business days after receiving the appeal of the grievance resolution.
5. The appeal of the Grievance resolution will be reviewed by a panel of qualified individuals.
6. The panel of qualified individuals will be made up of qualified reviewers who did not participate in the initial matter that created the grievance nor involved with the initial investigation of the grievance.

- 7. A reference to the benefit provision, guideline, protocol, reasons, policies, procedures, evidence, documentation or other similar criteria on which the appeal decision was based;
- 8. Notification that the member can obtain, upon request, reasonable access to and copies of all documents, including a copy of the clinical criteria/guideline, as relevant to the appeal decision was based;
- 9. The notice must include the title of each reviewer for a benefit appeal or, for the medical necessity review, the title, qualifications (e.g., MD, DO, PhD) and specialty (e.g., pediatrician, general surgeon, neurologist, clinical psychologist) of each clinical reviewer and the title for each nonclinical reviewer. It must also specifically state that these individuals participated in the appeal review. Participant names do not need to be included in the written notification to members, but must be provided to members upon request; and
- 10. The department, address, and telephone number through which the member may contact a qualified representative to obtain more information about the resolution of the appeal, the procedures governing the appeal, and further remedies allowed by law.

F. REVIEW / REVISION HISTORY

11/2014 (Initial Release to P&P Committee), 04/2015, 09/2015

Tracking history commenced January 2014			
Review	Revision	Date	Description of Changes
<input checked="" type="checkbox"/>	<input type="checkbox"/>	11/2014	Initial Release
<input checked="" type="checkbox"/>	<input type="checkbox"/>	04/2015	Added Indiana regulatory information.
<input type="checkbox"/>	<input type="checkbox"/>	09/2015	2015 Annual Review. Grammatical and formatting changes.

G. SOURCE DOCUMENTS

- 1. URAC Core 35 – v.6.0
- 2. CareSource Just4Me Evidence of Coverage -- Section 8
- 3. NCQA RR:2 Element A
- 4. Record Retention Policy

H. ATTACHMENTS

I. RELATED & PRIOR POLICIES/PROCEDURES

Adverse Benefit Determination Appeals Policy



POLICY / PROCEDURE		
Effective Date	Last Review / Revision Date	Next Annual Review Date
02/2015	09/2015	09/2016
Attachments		
<input checked="" type="checkbox"/> Yes		<input type="checkbox"/> No
Department	Process Owner	Policy Inventory No.
Customer Advocacy Operations	Melissa Mougey	QI-26-M

Product line:	Corresponding State:
Health Insurance Marketplace	
Health Insurance Marketplace	Indiana

A. POLICY / PROCEDURE TITLE

Customer Advocacy Operations - Appeal of Grievance and Adverse Benefit Determination - IN

B. DESCRIPTION / PURPOSE

To maintain a formal appeal process for the denial of member and provider pre and post clinical services, Expedited Appeals as well as Grievance Determination appeals. CareSource will ensure all clinical appeals are processed in accordance with federal and state regulations and accreditation standards.

C. DEFINITIONS

1. **Adverse Benefit Determination** - A decision by CareSource to deny, reduce, or terminate a requested Health Care Service or Benefit in whole or in part, including all of the following:
 - a. A determination that the Health Care Service does not meet the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, including Experimental or Investigational Services;
 - i. A determination of your eligibility for Benefits under the Plan;
 - ii. A determination that a Health Care Service is not a Covered Service;
 - iii. The imposition of an Exclusion or other limitation on Benefits that would otherwise be covered;
 - iv. A determination not to issue you coverage, if applicable to this Plan; or
 - v. A determination to rescind coverage under the Plan.
2. **Appeal (or internal appeal)** - The review by the Plan of an Adverse Benefit Determination:
 - a. **Standard Clinical Appeal** - A request to review a determination not to certify an admission, extension or stay, or other health care services conducted by a peer reviewer who was not involved in any previous denial determination/non-certification decision pertaining to the same episode or care.
 - b. **Expedited/Emergent Care Appeal**- An appeal process utilized for an episode of care where the application of standard resolution time frames could:
 - i. Seriously jeopardize the life or health of the member or the ability of the consumer to regain maximum function; or

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- ii. The opinion of a health care professional with knowledge of the consumer'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 case.

3. A Claim Involving Emergent Care means:

- a. Any claim for medical care or treatment with respect to which the application of the time periods for making non-emergent care determinations:
 - i. Could seriously jeopardize the member's life or health or your ability to regain maximum function, or,
 - ii. In the opinion of a Physician with knowledge of your 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 claim.
- b. Except as provided below, a claim involving Emergent Care Services is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
- c. Any claim that a Physician with knowledge of your medical condition determines is a claim involving emergent care, and we shall defer to such determination by the attending Provider.

4. Authorized Representative - An individual who represents a Covered Person in an internal appeal or external review process of an Adverse Benefit Determination and who is any one of the following:

- a. A person to whom the member has given express, written consent to represent them in an internal appeals process or external review process of an Adverse Benefit Determination;
- b. A person authorized by law to provide substituted consent for the member; or
- c. A family member or a treating health care professional when, and only when, the member is unable to provide consent.

5. Business Day - Monday through Friday, excluding any state or federal holiday observed by CareSource.

6. External Review - A review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to State and federal law. **Independent Review Organization (IRO)** - An entity that conducts independent External Reviews of Final Internal Adverse Benefit Determinations.

7. Member - Has the same meaning as Covered Person, which includes an Enrollee or an eligible dependent of an Enrollee.

8. Enrollee – An individual who has contracted for or who participates in coverage under a health maintenance organization contract providing payment, reimbursement, or indemnification for costs of health care for: (1) the individual, (2) eligible dependents of the individual, or (3) both the individual and the individual's eligible dependents.

9. Plan – The [CareSource Just4Me™] Plan.

10. Concurrent Service Requests for Benefits – A request for Benefits during the course of treatment or admission. If a Concurrent review request is not approved, a Covered Person who is receiving an ongoing course of treatment may proceed with an expedited External Review while simultaneously pursuing an internal appeal.

11. Health Care Professional- A person licensed, certified, or registered under parts 61-65 or 161-183 of the Public Health Code. A health care professional is considered a covered entity under the HIPAA regulations.

12. NOA- "Notice of Action."

13. Peer Reviewer – A physician or health care professional with the same profession and in a similar specialty as the physician or health care professional providing the care to the member.

14. Practitioner - A professional who provides health care services. Practitioners are usually licensed as required by law such as: Physicians, Dentists, Chiropractors, Nurse Clinicians, etc.

15. **Prospective Service Requests for Benefits or Pre-Service Requests** - A request for Benefits which the Plan must approve or in which a Covered Person must notify the Plan before non-Emergent Care Services are provided.
16. **Provider**- Facility or provider of services (i.e. – Durable Medical Equipment (DME) company, ambulance provider, Home Care agency, etc.).
17. **Retrospective Post-Service** - A claim for reimbursement of the cost of non-Emergent Care Services that has already been provided.
18. **Emergent Care Services Requests for Benefits** - a request for Benefits provided in connection with Emergent Care Services, meaning treatment of an unexpected Sickness or Injury that is not life-threatening but requires Outpatient medical care that cannot be postponed and requires prompt medical attention to avoid complications and unnecessary suffering.

D. POLICY

It is the policy of CareSource to maintain a formal clinical appeal process for the denial of medical services. CareSource will ensure all clinical appeals are processed in accordance with federal and state regulations and accreditation standards. This policy applies to members, physicians, providers and facilities.

E. PROCEDURE

1. APPEAL OF A GRIEVANCE RESOLUTION

- a. Members have one hundred eighty (180) calendar days from receipt of the Grievance resolution notice to file the appeal of a Grievance resolution.
- b. Member may file an appeal of a Grievance resolution orally or in writing.
- c. CareSource will provide language service to members if requested during the appeal process.
 - i. Oral interpretation is available for any language.
 - ii. Written translation is available in prevalent language as applicable.
 - iii. Written alternative formats may be available as needed.
 - iv. How to access our interpretation and translation services as well as alternative formats that can be provided.
- d. CareSource will give members, at no cost, all reasonable assistance in filing an appeal or a state hearing request including (but not limited to):
 - i. Providing oral interpreter and oral translation services, sign language assistance, and access to our grievance system through a toll-free number with text telephone yoke (TTY) and interpreter capability.
- e. CareSource will send an acknowledgement letter to the member within three (3) business days after receiving the appeal of the grievance resolution.
- f. The appeal of the Grievance resolution will be reviewed by a panel of qualified individuals.
- g. The panel of qualified individuals will be made up of qualified reviewers who did not participate in the initial matter that created the grievance nor involved with the initial investigation of the grievance.
- h. CareSource will resolve the appeal no later than forty-five (45) calendar days after the appeal is filed. **NOTE:** For businesses fully insured by an insurance company (pursuant to Indiana Code 27-8-17-12(b)), the following timeframe will apply: The determination of an appeal must be completed within thirty (30) calendar days after the appeal is filed and all information necessary to complete the appeal is received.

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- i. CareSource will send written notification to member within five (5) business days of CareSource completing the investigation.
- j. For grievance resolutions appeals, the organization will issue written notification of the decision to the member or the member's authorized representative that includes the following:

(If the notice is sent electronically including e-mail or facsimile then an agreement must be signed in advance on receiving such notices electronically)

- i. The decision reached;
- ii. A statement of CareSource's understanding of the member's appeal;
- iii. A description of the resolution reached by CareSource stated in clear terms and the contract basis or medical rationale for the resolution stated in sufficient detail for the member to respond further to CareSource's position and in a culturally and linguistically appropriate manner;
- iv. Notice of the enrollee's right to further remedies allowed by law, including the right to review by an IRO;
- v. Form for the release of medical records to allow the IRO to obtain necessary medical records from the insurers or providers;
- vi. A reference to the benefit provision, guideline, protocol, reasons, policies, procedures, evidence, documentation or other similar criteria on which the appeal decision was based;
- vii. Notification that the member can obtain, upon request at no cost, reasonable access to and copies of all documents, including a copy of the clinical criteria/guideline, as relevant to the appeal decision was based;
- viii. The notice must include the title of each reviewer for a benefit appeal or, for the medical necessity review, the title, qualifications (e.g., MD, DO, PhD) and specialty (e.g., pediatrician, general surgeon, neurologist, clinical psychologist) of each clinical reviewer and the title for each nonclinical reviewer. It must also specifically state that these individuals participated in the appeal review. Participant names do not need to be included in the written notification to members, but must be provided to members upon request; and
- ix. The department, address, and telephone number through which the member may contact a qualified representative to obtain more information about the resolution of the appeal, the procedures governing the appeal, and further remedies allowed by law.

2. APPEAL OF ADVERSE BENEFIT DETERMINATION TIMEFRAMES

The member receives information regarding the standard expedited appeals rights in the Adverse Benefits Determination Notice.

- a. Appeal acknowledgement letter will be mailed with in three (3) business days after receiving the Appeal.
- b. CareSource will provide language service to members if needed during the appeal process.
- c. CareSource will give members, at no cost, all reasonable assistance in filing an appeal request including (but not limited to):
 - i. Providing oral interpreter and oral translation services, sign language assistance, and access to our grievance system through a toll-free number with text telephone yoke (TTY) and interpreter capability.

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- d. Emergent Care Request for Benefits. If the Plan denies an individual's request for Emergent Care Services, then the Plan must notify the individual of the Plan's benefit determination as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receiving the individual's request for the appeal. The individual does not need to submit Emergent Care appeals in writing. The individual should call CareSource as soon as possible to appeal an Emergent Care request for Benefits.
- e. Pre-Service Request for Benefits. The individual must appeal an Adverse Benefit Determination related to Pre-Service Requests for Benefits no later than one hundred eighty (180) calendar days after receiving the Adverse Benefit Determination. Pre-service appeals must be completed within fifteen (15) days of receiving the appeal.
- f. Post-Service Claims. The individual must appeal an Adverse Benefit Determination related to Post-Service Requests for Benefits no later than one hundred eighty (180) calendar days after receiving the Adverse Benefit Determination. Post-service appeals must be completed within forty-five (45) days of receiving the appeal.
- g. Concurrent Services Requests. Appeals relating to ongoing emergencies or denials of continued hospital stays (Concurrent Care Claims Involving Emergent Care) are referred directly to an expedited appeal process for investigation and resolution within seventy-two (72) hours of receipt of the request Appeals for Concurrent Claims (Non-Emergent) will be concluded in accordance with the medical or dental immediacy of the case.

3. APPEAL REQUIREMENTS

- a. CareSource allows the member one hundred eighty (180) calendar days from the receipt of the notice of Adverse Benefit Determinations to request a clinical appeal of CareSource's decision.
- b. Members may file the appeal either orally or in writing
- c. CareSource will provide language service to members if needed during the appeal process
- d. The appeal request should include:
 - i. Member name and ID number as shown on the ID card;
 - ii. The Provider's name;
 - iii. The date of the medical service;
 - iv. The reason the member disagrees with the denial; and
 - v. Any documentation or other written information to support the request.
- e. CareSource, upon request and free of charge, will send the member a copy of any guideline, criteria, or clinical rationale CareSource relied upon in making our decision. Additionally, upon request and free of charge, CareSource will provide the member the diagnosis and treatment codes and their corresponding meaning(s) that are relevant to the member's claim. To receive this information, the member needs to contact Member Services.
- f. The member may authorize a representative to act on their behalf in submitting an appeal. Members must provide written consent to be represented by others including, but not limited to, attorneys, physicians, family members or friends, during the appeals process. Written consent may be in the form of a letter or an authorization form signed by the member. CareSource must begin the clinical appeal upon receipt of the written consent of the member.
- g. The Clinical Appeals department will contact the appropriate providing parties and member, offering the opportunity to submit additional written comments, documents, records and other information relating to the case.
- h. All available case information will be taken into account during a full investigation of the appeal including any aspects of the clinical care involved without regard as to whether such information was submitted or considered in the initial consideration of the case.
 - i. The appeal will be reviewed by a panel of qualified individuals.
 - j. The member has the right to appear in front of the panel or communicate with the panel through other appropriate means if they are not able to appear in person.
- k. CareSource will send the member any new or additional information and rationale that is considered, relied upon, or generated by the insurer in connection with the appeal. This information will be provided free of charge and sufficiently in advance of the date on which the

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- notice of final internal adverse benefit determination is required to be provided to give the member a reasonable opportunity to respond prior to the date.
- l. Before CareSource can issue a final adverse benefit determination regarding the appeal based on new or additional rationale, the member will be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided to give the claimant a reasonable opportunity to respond.
 - m. CareSource will utilize current clinical coverage guidelines in determining whether health care services are covered services.
 - n. CareSource will provide continued coverage pending the outcome of the internal appeal. CareSource is prohibited from reducing or terminating an ongoing course or treatment without providing advance notice and an opportunity for advance review. Members in urgent care situations and members receiving an ongoing course of treatment may be allowed to proceed with expedited external review at the same time as the internal appeals process.
 - o. CareSource's decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (claims adjudicator or medical expert) will not be made based on the likelihood that the individual will support a denial of benefits.
 - p. Clinical appeal considerations are conducted by health professionals who:
 - i. Are clinical peers same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment;
 - ii. Hold an active, unrestricted license to practice medicine or a health profession in a state or territory of the United States;
 - iii. Unless expressly allowed by state or federal law or regulation, are located in a state or territory of the United States when conducting an appeals consideration;
 - iv. Are board certified (if applicable) by: A specialty board approved by the American Board of Medical Specialties (doctors of medicine); or The Advisory Board of Osteopathic Specialists from the major areas of clinical services (doctors of osteopathic medicine);
 - v. Are neither the individual who made the original non-certification, nor the subordinate of such an individual; and
 - vi. Do not have a direct business interest with the enrollee or the health care provider who previously recommended the treatment, procedure, or service giving rise to the appeal.
 - q. For clinical appeal upheld determinations, the organization issues written notification of the appeal decision to the member, member's authorized representative, the member's physician and/or other ordering provider or facility rendering service that includes the following:
(If the notice is sent electronically including e-mail or facsimile then an agreement must be signed in advance or receiving such notices electronically)
 - i. The decision reached;
 - ii. A statement of CareSource's understanding of the member's appeal;
 - iii. A description of the resolution reached by CareSource stated in clear terms and the contract basis or medical rationale for the resolution stated in sufficient detail for the member to respond further to CareSource's position and in a culturally and linguistically appropriate manner;
 - iv. The date in question and if for preauthorization denote as such;
 - v. Notice of the enrollee's right to further remedies allowed by law, including the right to review by an IRO;
 - vi. Form for the release of medical records to allow the IRO to obtain necessary medical records from the insurers or providers;

- vii. A reference to the benefit provision, guideline, protocol, reasons, policies, procedures, evidence, documentation or other similar criteria on which the appeal decision was based;
 - viii. Notification that the member can obtain, upon request, reasonable access to and copies of all documents, including a copy of the clinical criteria/guideline, as relevant to the appeal decision was based;
 - ix. The notice must include the title of each reviewer for a benefit appeal or, for the medical necessity review, the title, qualifications (e.g., MD, DO, PhD) and specialty (e.g., pediatrician, general surgeon, neurologist, clinical psychologist) of each clinical reviewer and the title for each nonclinical reviewer. It must also specifically state that these individuals participated in the appeal review. Participant names do not need to be included in the written notification to members, but must be provided to members upon request; and
 - xi. The department, address, and telephone number through which the member may contact a qualified representative to obtain more information about the resolution of the appeal, the procedures governing the appeal, and further remedies allowed by law.
- r. For clinical appeal overturned determinations, the organization issues written notification of the appeal decision to the member, the member's physician and/or other ordering provider or facility rendering services that includes:
- i. The specific service/procedure that is approved;
 - ii. The dates the service/procedure can be rendered or has been rendered; and
 - iii. The assigned approval number (authorization number).

If CareSource reverses the Adverse Benefit Determination decision, CareSource will authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires.

4. EXPEDITED CLINICAL APPEAL REQUIREMENTS

- a. Members may request an expedited appeal for:
 - i. Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:
 - aa. Could seriously jeopardize the member's life or health or the member's ability to regain maximum function; or,
 - bb. 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 claim.
- b. Except as provided below, a claim involving Emergent Care Services is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.
 - i. Any claim that a Physician with knowledge of your medical condition determines is a claim involving emergent care, and we shall defer to such determination by the attending Provider.
- c. Expedited Appeals can be filed orally, in writing, or by other reasonable means.

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- d. CareSource will provide language service to members if needed during the appeal process.
- e. The date of the verbal filing will be considered the filing date of the expedited appeal.
- f. The member, the member's authorized representative or a provider acting on the member's behalf may request an expedited appeal when the standard timeframe of appeal (45 calendar days) could seriously jeopardize the member's life, health, or the member's ability to regain maximum function.
- g. The member's authorized representative acting on the member's behalf must have the member's written consent to file an expedited appeal. In the event the member is incapacitated or unable to provide verbal or written consent or unable to designate an authorized representative, CareSource will process the expedited appeal request if the request meets expedited criteria without verbal or written consent from the member.
- h. The request for an expedited appeal is usually made by telephone and can be received by any department at CareSource.
- i. If the expedited clinical appeal fails to meet expedited criteria, the member or their authorized representative will be contacted via telephone and in writing advising that the matter does not meet expedited criteria and will be handled under the standard clinical appeals process. A follow-up letter is sent to the member within twenty-four (24) hours confirming the matter does not meet expedited criteria and providing expedited grievance rights. However, if a physician with knowledge of the member's condition indicates that the appeal must be processed as "expedited," CareSource will render an expedited decision.
- j. Additional information will be accepted over the telephone, fax, or other acceptable means.
- k. CareSource will complete the review of the member's Expedited Appeal as soon as possible given the member's medical needs, but no later than seventy-two (72) hours after CareSource's receipt of the Expedited Appeal request. **NOTE:** For businesses fully insured by an insurance company (pursuant to Indiana Code 27-8-17-12(c)), the following timeframe will apply: The determination of an expedited appeal shall be completed within forty-eight (48) hours after the appeal is initiated and all information necessary to complete the appeal is received.
- l. Clinical appeal considerations are conducted by health professionals who:
 - i. Are clinical peers, same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment;
 - ii. Hold an active, unrestricted license to practice medicine or a health profession in a state or territory of the United States;
 - iii. Unless expressly allowed by state or federal law or regulation, are located in a state or territory of the United States when conducting an appeals consideration;
 - iv. Are board certified (if applicable) by: A specialty board approved by the American Board of Medical Specialties (doctors of medicine); or The Advisory Board of Osteopathic Specialists from the major areas of clinical services (doctors of osteopathic medicine);
 - v. Are neither the individual who made the original non-certification, nor the subordinate of such an individual; and
 - vi. Do not have a direct business interest with the enrollee or the health care provider who previously recommended the treatment, procedure, or service giving rise to the appeal.

- m. The CareSource member, the member's attending physician, ordering Provider and the facility rendering the service will be notified by telephone, facsimile or other available similarly expeditious method within the permitted time frame. A written notice of the decision will also be mailed to the member or their authorized representative along with the provider and or facility.
- n. For clinical appeal upheld determinations, the organization issues written notification of the appeal decision to the member, member's authorized representative, the member's physician and/or other ordering provider or facility rendering service that includes the following:

(If the notice is sent electronically including e-mail or facsimile then an agreement must be signed in advance or receiving such notices electronically)

 - i. The decision reached;
 - ii. A statement of CareSource's understanding of the member's appeal;
 - iii. A description of the resolution reached by CareSource stated in clear terms and the contract basis or medical rationale for the resolution stated in sufficient detail for the member to respond further to CareSource's position and in a culturally and linguistically appropriate manner;
 - iv. The date in question and if for preauthorization denote as such;
 - v. Notice of the enrollee's right to further remedies allowed by law, including the right to review by an IRO;
 - vi. Form for the release of medical records to allow the IRO to obtain necessary medical records from the insurers or providers;
 - vii. A reference to the benefit provision, guideline, protocol, reasons, policies, procedures, evidence, documentation or other similar criteria on which the appeal decision was based;
 - viii. Notification that the member can obtain, upon request, reasonable access to and copies of all documents, including a copy of the clinical criteria/guideline, as relevant to the appeal decision was based; and
 - ix. The department, address, and telephone number through which the member may contact a qualified representative to obtain more information about the resolution of the appeal, the procedures governing the appeal, and further remedies allowed by law.
- o. For clinical appeal overturned determinations, the organization issues written notification of the appeal decision to the member, the member's physician and/or other ordering provider or facility rendering services that includes:
 - i. The specific service/procedure that is approved;
 - ii. The dates the service/procedure can be rendered or has been rendered; and
 - iii. The assigned approval number (authorization number).
- p. A member may file a Concurrent Expedited Appeal and an Expedited External Review under the following conditions:
 - i. Any claim for medical care or treatment with respect to which the application of the time periods for making non-emergent care determinations:
 - aa. Could seriously jeopardize the member's life or health, or

- bb. Could seriously jeopardize member's ability to regain maximum function.
- q. The Expedited Appeal process can also occur at the same time as the Expedited External Review for an Appeal related to a Claim Involving Emergent Care and a Concurrent Care Claim.

5. RECORD RETENTION

- a. CareSource will maintain will maintain written records that document certain information about all grievances and appeals received during a calendar year (the grievance register). The Grievance Register will contain, at a minimum, the following information about each grievance and appeal:
 - i. (1) A general description of the basis for the grievance using the categories in block 3 of the grievance procedures report set forth in section 14 of this rule;
 - ii. (2) Date received;
 - iii. (3) Date investigated or reviewed;
 - iv. (4) Date resolved;
 - v. (5) Description of resolution;
 - vi. (6) Date appeal, if any, was received;
 - vii. (7) Date of appeals hearing or review;
 - viii. (8) Date appeal was resolved;
 - ix. (9) Description of resolution of the appeal;
 - x. (10) Name of enrollee and enrollee's representative, if any, who filed, or upon whose behalf was filed, the grievance; and
 - xi. (11) Names and titles of all persons who investigated, reviewed, and resolved the grievance.
- b. CareSource will retain each grievance register until the commissioner has conducted an examination of the CareSource and adopted a final report of the examination that contains a review of the register for the calendar year covered by the grievance register.

6. CONTACT INFORMATION

State of Indiana Department of Insurance
 Consumer Services Division
 311 West Washington Street, Suite 300
 Indianapolis, Indiana 46204
 Consumer Hotline: (800) 622-4461; (317) 232-2395
 Complaints can be filed electronically at www.in.gov/idoi

F. REVIEW / REVISION HISTORY

02/2015 (Initial Release to P&P Committee), 04/2015, 09/2015

<i>Tracking history commenced January 2011</i>			
Review	Revision	Date	Description of Changes
<input checked="" type="checkbox"/>	<input type="checkbox"/>	02/2015	Initial Release to P&P Committee
<input type="checkbox"/>	<input checked="" type="checkbox"/>	04/2015	Added additional verbiage clarification, cost verbiage, interpreter/translation verbiage, department name and AR date change.
<input checked="" type="checkbox"/>	<input type="checkbox"/>	09/2015	2015 Annual Review – Changed “Urgent” to “Emergent”. Spelled out numbers for clarity. Minor grammatical changes. Format changes.

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G. SOURCE DOCUMENTS

1. NCQA UM 8- 2011, 2013,2014
2. NCQA UM 9 v7.0 2013, 2014
3. CareSource Just4Me Evidence Of Coverage and Health Insurance Contracts for Individual and Family –Indiana Just 4 Me
4. IC 27-8-17-12
5. Indiana Code 27-13-10, et seq.
6. 760 IAC 1-46-3
7. 760 IAC 1-46-5
8. 760 IAC 1-46-6
9. 760 IAC 1-46-7
10. 760 IAC 1-46-9
11. 760 IAC 1-46-10
12. 760 IAC 1-46-11
13. 760 IAC 1-46-12

H. ATTACHMENTS

ATTACHMENT A - Indiana Appeal Quick Tool

I. RELATED & PRIOR POLICIES/PROCEDURES

IN Exchange Appeals Quick Tool

****Meets requirements: 760:1-46-6 and IC 27-8-17-12

1. Entire Process has to be completed For ALL Appeals

2. Member calls Customer Advocate
3. Customer Advocate documents call in Streamline
4. Customer Advocate routes the appeal off to Grievance and Appeal Specialist
5. Grievance and Appeal Specialist logs appeal in Facets
6. Grievance and Appeal Specialist sends appeal to Clinical Appeal mailbox
7. ASHC pulls appeal from mailbox
8. ASHC prints screenshots from Facets
9. ASHC documents in CCA and Sharepoint
10. ASHC Requests information from Provider
11. Provider has 48 hours to submit additional information
12. If provider submits additional information, ASHC will send a copy of the new information to the member
13. Member has 10 calendar days to submit comments
14. Member submits comments about the new information
15. Appeal is passed off to CAN by the ASHC
16. CAN Documents summary of submitted information in CCA
17. CAN routes to physician reviewer (Like Specialty)
18. Physician completes review
19. Appeal is routed to CAN by Physician
20. CAN retrieves Appeal
21. CAN documents in Facets
22. CAN creates Letter
23. CAN prints Letter
24. CAN Mails letter to member, provider, and /or facility
25. CAN closes appeal in Facets
26. Clerk scans appeal into OnBase for electronic record retention.
27. Original paper file is stored until audit is completed



POLICY / PROCEDURE		
Effective Date	Last Review / Revision Date	Next Annual Review Date
12/2014	09/2015	09/2016
Attachments		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
Department	Process Owner	Policy Inventory No.
Quality Improvement	Melissa Mougey	QI-25-M

Product line:	Corresponding State:
Health Insurance Marketplace	
Health Insurance Marketplace	Indiana

A. POLICY / PROCEDURE TITLE

Quality Improvement - Independent External Review of Clinical Appeals

B. DESCRIPTION / PURPOSE

To define a process to ensure that members or their authorized representatives are offered an External Review process of an Adverse Benefit Determination after all internal Appeal mechanisms have been exhausted.

C. DEFINITIONS

-
1. **Adverse Benefit Determination** - a decision by CareSource to deny, reduce, or terminate a requested Health Care Service or Benefit in whole or in part, including all of the following:

A determination that the Health Care Service does not meet the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, including Experimental or Investigational Services;

- A determination of the member's eligibility for Benefits under the Plan;
- A determination that a Health Care Service is not a Covered Service;
- The imposition of an Exclusion or other limitation on Benefits that would otherwise be covered;
- A determination not to issue the member coverage, if applicable to this Plan; or
- A determination to rescind coverage under the Plan.

2. **Authorized Representative** - An individual who represents a Covered Person in an internal appeal or external review process of an Adverse Benefit Determination and who is any one of the following:

- A person to whom the member has given express, written consent to represent the member in an internal appeals process or external review process of an Adverse Benefit Determination;
- A person authorized by law to provide substituted consent for the member; or

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- A family member or a treating health care professional when, and only when, the member is unable to provide consent.
3. **Concurrent Service Requests for Benefits** - A request for Benefits during the course of treatment or admission. If a Concurrent review request is not approved, a Covered Person who is receiving an ongoing course of treatment may proceed with an expedited External Review while simultaneously pursuing an internal appeal.
 4. **Business Day** - Monday through Friday, excluding any state or federal holiday observed by CareSource.
 5. **Expedited External Review** – Review of a Final Adverse Benefit Determination by an Independent Review Organization or Entity that meets Expedited External Review criteria.
 6. **Enrollee** – An individual who has contracted for or who participates in coverage under a health maintenance organization contract providing payment, reimbursement, or indemnification for costs of health care for: (1) the individual, (2) eligible dependents of the individual, or (3) both the individual and the individual's eligible dependents.
 7. **External Review** - a review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to State and federal law.
 8. **Final Internal Adverse Benefit Determination** – An Adverse Benefit Determination that is upheld at the completion of the Plan's internal appeals process.
 9. **Health Care Professional** - A person licensed, certified, or registered under parts 61-65 or 161-183 of the Public Health Code. A health care professional is considered a covered entity under the HIPAA regulations.
 10. **IDOI** - Indiana Department of Insurance
 11. **Independent Review Organization (IRO)** - An entity that conducts independent External Reviews of Final Internal Adverse Benefit Determinations.
 12. **Medical Necessity** - Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
 13. **Member or Covered Person** – An individual who is enrolled under the Plan.
 14. **Member** - Has the same meaning as Covered Person, which includes an Enrollee or an eligible dependent of an Enrollee.
 15. **NOA** - "Notice of Action".
 16. **Plan** - The [CareSource Just4Me™] Plan.
 17. **Peer Reviewer** – A physician or health care professional with the same profession and in a similar specialty as the physician or health care professional providing the care to the member.

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18. **Practitioner** - A professional who provides health care services. Practitioners are usually licensed as required by law such as: Physicians, Dentists, Chiropractors, Nurse Clinicians, etc.
19. **Prospective Service Requests for Benefits or Pre-Service Requests** - A request for Benefits which the Plan must approve or in which a Covered Person must notify the Plan before non-Urgent Care Services are provided.
20. **Provider** - Facility or provider of services (i.e. – Durable Medical Equipment (DME) company, ambulance provider, Home Care agency, etc.).
21. **Standard External Review** - Review of a Final Adverse Benefit Determination by an Independent Review Organization that meets External Review criteria.

D. POLICY

It is the policy of CareSource to ensure that members or their authorized representatives are offered an External Review process of an Adverse Benefit Determination after all internal appeal mechanisms have been exhausted. The Adverse Benefit Determination may involve an issue of Medical Necessity, appropriateness, health care setting, level of care, or effectiveness. The Adverse Benefit Determination can also be a decision to deny health benefit plan coverage or to rescind coverage.

E. PROCEDURE

1. External grievance procedure established

A health maintenance organization shall establish and maintain an external review procedure for the resolution of appeals regarding the following:

A. The following determinations made by the health maintenance organization or an agent of the health maintenance organization regarding a service proposed by the treating physician:

- i. An adverse utilization review determination;
- ii. An adverse determination of medical necessity; and
- iii. A determination that a proposed service is experimental or investigational.

B. The health maintenance organization's decision to rescind an individual contract or a group contract.

2. Requirements of procedure

An external grievance procedure established must:

1. Allow an enrollee or the enrollee's representative to file a written request with the health maintenance organization for an appeal of the health maintenance organization's grievance resolution under not later than one hundred eighty (180) days after the enrollee is notified of the resolution;

2. Provide for:

A. An expedited appeal for a grievance related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the enrollee's:

- i. Life or health; or
- ii. Ability to reach and maintain maximum function; or

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B. a standard appeal for a grievance.

3. An enrollee may file not more than one (1) appeal of a health maintenance organization's grievance resolution.

4. When an External Review request is filed:

a. The health maintenance organization shall:

1. Select a different independent review organization for each appeal filed; and
2. Rotate the choice of an independent review organization among all certified independent review organizations before repeating a selection.

5. The independent review organizations shall assign a medical review professional who is board certified in the applicable specialty for resolution of an appeal.

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

- a. The health maintenance organization.
- b. Any officer, director, or management employee of the health maintenance organization.
- c. The physician or the physician's medical group that is proposing the service.
- d. The facility at which the service would be provided.
- e. 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 the health maintenance organization and may have an affiliation that is limited to staff privileges at the health facility if the affiliation is disclosed to the enrollee and the health maintenance organization before commencing the review and neither the enrollee nor the health maintenance organization objects.

7. The enrollee shall not pay any of the costs associated with the services of an independent review organization under this chapter. All costs must be paid by the health maintenance organization.

3. Cooperation with review organization and requirements of enrollee

(An enrollee who files an appeal shall:

- A. Not be subject to retaliation for exercising the enrollee's right to an appeal;
- B. Be permitted to utilize the assistance of other individuals, including physicians, attorneys, friends, and family members throughout the review process;
- C. Be permitted to submit additional information relating to the proposed service throughout the review process; and
- D. Cooperate with the independent review organization by:
 - aa. Providing any requested medical information; or

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bb. Authorizing the release of necessary medical information.

9. A health maintenance organization shall cooperate with an independent review organization selected by promptly providing any information requested by the independent review organization

4. Requirements of independent review organization

An independent review organization shall:

1. For an expedited appeal filed within seventy-two (72) hours after the appeal is filed; or
2. For a standard appeal filed within fifteen (15) business days after the appeal is filed;

make a determination to uphold or reverse the health maintenance organization's grievance resolution based on information gathered from the enrollee or the enrollee's designee, the health maintenance organization, and the treating physician, and any additional information that the independent review organization considers necessary and appropriate.

- a. When making the determination, the independent review organization shall apply:
 - i. standards of decision making that are based on objective clinical evidence; and
 - ii. the terms of the enrollee's benefit contract.
- b. The independent review organization shall notify the health maintenance organization and the enrollee of the determination made under this section:
 - i. for an expedited appeal filed within twenty-four (24) hours after making the determination; or
 - ii. for a standard appeal filed within seventy-two (72) hours after making the determination.

5. Information from independent review organization

Upon the request of an enrollee who is notified that the independent review organization has made a determination, the independent review organization shall provide to the enrollee all information reasonably necessary to enable the enrollee to understand the:

- a. Effect of the determination on the enrollee; and
- b. Manner in which the health maintenance organization may be expected to respond to the determination.

6. Determination binding on health maintenance organization

A determination made by the IRO is binding on the health maintenance organization.

7. Reconsideration of resolution

- a. If at any time during an external review, the enrollee submits information to the health maintenance organization that is relevant to the health maintenance organization's resolution and was not considered by the health maintenance organization:

aa. The health maintenance organization shall reconsider the health maintenance organization's resolution; and

bb. The independent review organization shall cease the external review process until the reconsideration is completed.

- b. A health maintenance organization to which information is submitted shall reconsider the resolution based on the information and notify the enrollee of the health maintenance organization's decision:

aa. Within seventy-two (72) hours after the information is submitted for a reconsideration related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the enrollee's:

- i. life or health; or

- ii. ability to reach and maintain maximum function.
- bb. Within fifteen (15) calendar days after the information is submitted for a reconsideration.
- c. If the decision reached is adverse to the enrollee, the enrollee may request that the independent review organization resume the external review.

8. Confidentiality

Documents and other information created or received by the independent review organization or the medical review professional in connection with an external review:

- a. Are not public records;
- b. May not be disclosed; and
- c. Must be treated in accordance with confidentiality requirements of state and federal law.

9. Medicare review

If an enrollee has the right to an external review under Medicare, the enrollee may not request an external review under this chapter.

10. Annual Notification

CareSource will notify members at least annually in the member newsletter of their right to file an external review of an appeal.

F. REVIEW / REVISION HISTORY

12/2014 (Initial Release to P&P Committee), 04/2015, 09/2015

<i>Tracking history commenced January 2011</i>			
Review	Revision	Date	Description of Changes
<input checked="" type="checkbox"/>	<input type="checkbox"/>	12/2014	Initial Release to P&P Committee
<input checked="" type="checkbox"/>	<input type="checkbox"/>	04/2015	Minor changes.
<input checked="" type="checkbox"/>	<input type="checkbox"/>	09/2015	2015 Annual Review. Grammatical and formatting changes. Definitions sorted by alphabetical order. Duplicate "Plan" definition removed.

G. SOURCE DOCUMENTS

1. NCQA UM 8, v.2013
2. NCQA UM 9 v 2013
3. CareSource Just4Me EOC
4. 29 CFR §2560.503-1
5. IC 27-13-10.1-3 et seq.

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H. ATTACHMENTS

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