

Indiana After Hours Line Procedure – Commercial Medical

Overview

Indiana Insurance Regulation 760:1-59-8 requires that a toll free telephone line is available for members to file a grievance, appeal, or obtain information concerning grievance/appeal procedures. In addition, a line must be available after business hours that allows members to leave a message. Responses to any messages are returned the next business day.

This procedure provides guidance for the Grievance and Appeal (G&A) specialists to retrieve and respond to the messages on the toll free line after business hours.

Who Does What

The Customer Care Specialist responds to grievance/appeal inquiries, accepts verbal filings, and provides information about G&A procedures during normal business hours.

The G&A Specialist retrieves the voice mails from the after-hours line each business day. The G&A specialist also responds to the caller within the next business day after the call is received for calls related to G&A inquiries or forwards the call to the appropriate department for response.

Retrieving and Responding to the Voice Mail Procedure

The designated G&A Specialist follows these steps to retrieve the messages every business day.

Step	Action
1	Review the Expedite Line Team CSC mailbox for new messages (wave files) for the Indiana area codes listed during the first triage review of the day: <ul style="list-style-type: none">• 219• 260• 317• 574• 765• 812

Continued on next page

Indiana After Hours Line Procedure – Commercial Medical, Continued

Retrieving and Responding to the Voice Mail Procedure, continued

Step	Action															
2	<p>Does the mailbox include messages received from an Indiana area code?</p> <ul style="list-style-type: none"> • If yes, <ol style="list-style-type: none"> a. Listen to the call and note: <ul style="list-style-type: none"> ▪ Member ID number ▪ Member name ▪ Member phone number ▪ Reason for the call b. Go to the next step. • If no, the procedure is complete. 															
3	<p>Is the caller a Commercial member?</p> <ul style="list-style-type: none"> • If yes, go to the next step. • If no, go to step 6. 															
4	<p>Per Indiana requirements, call the member to acknowledge receipt of the message within the next business day after receipt of the call. Refer to the Resolution Team Call Authentication Job Aid.</p> <p>Review the chart below for guidance on the response to the member and the next step according to the nature of the call.</p> <table border="1"> <thead> <tr> <th>Nature of the call</th> <th>Tell the member</th> <th>Then...</th> </tr> </thead> <tbody> <tr> <td>How to file a grievance or appeal</td> <td>Basic information</td> <td>Process is complete</td> </tr> <tr> <td>Request for an expedited appeal</td> <td>NA - call will be made by the assigned specialist</td> <td>Return to the Expedited Appeal Traffic Control Procedure</td> </tr> <tr> <td>Status update of a filed grievance or appeal</td> <td>Basic information</td> <td>Process is complete</td> </tr> <tr> <td>Verbal submission of a standard grievance or appeal</td> <td>Basic information</td> <td>Go to the next step</td> </tr> </tbody> </table>	Nature of the call	Tell the member	Then...	How to file a grievance or appeal	Basic information	Process is complete	Request for an expedited appeal	NA - call will be made by the assigned specialist	Return to the Expedited Appeal Traffic Control Procedure	Status update of a filed grievance or appeal	Basic information	Process is complete	Verbal submission of a standard grievance or appeal	Basic information	Go to the next step
Nature of the call	Tell the member	Then...														
How to file a grievance or appeal	Basic information	Process is complete														
Request for an expedited appeal	NA - call will be made by the assigned specialist	Return to the Expedited Appeal Traffic Control Procedure														
Status update of a filed grievance or appeal	Basic information	Process is complete														
Verbal submission of a standard grievance or appeal	Basic information	Go to the next step														

Continued on next page

Indiana After Hours Line Procedure – Commercial Medical, Continued

Retrieving and Responding to the Voice Mail Procedure, continued

Step	Action												
5	<ul style="list-style-type: none"> a. Create an email with the WAV file attached. b. Include the Member information noted in Step 2 and a statement that an acknowledgment call was made to the member on [Date] at [Time]. c. Forward the email to CommercialGAIntakeInquiries@humana.com to complete the standard case set up. d. Return to the Expedited Appeal Traffic Control Procedure. 												
6	<ul style="list-style-type: none"> a. Create an email with the WAV file attached. b. Include the Member information noted in Step 2. c. Forward the email according to the table below: <table border="1" data-bbox="581 783 1414 1218"> <thead> <tr> <th>If...</th> <th>Then...</th> </tr> </thead> <tbody> <tr> <td>Medicare</td> <td>ExpediteLineTeamLSC@humana.com</td> </tr> <tr> <td>Medicaid <i>before</i> 5 pm est M-F</td> <td>MedicareGARightFax@humana.com -CC Mary Eagan and Steve Coffey -Document 'Expedite' in the subject line -Include call transcription if is a wav file</td> </tr> <tr> <td>Medicaid <i>after</i> 5 pm est M-F and on weekend</td> <td>MCDEpedite@humana.com -Include call transcription if is a WAV file</td> </tr> <tr> <td>Puerto Rico</td> <td>G&ApuertoRicoTeam@humana.com</td> </tr> <tr> <td>Tricare</td> <td>Cindy Petrous</td> </tr> </tbody> </table>	If...	Then...	Medicare	ExpediteLineTeamLSC@humana.com	Medicaid <i>before</i> 5 pm est M-F	MedicareGARightFax@humana.com -CC Mary Eagan and Steve Coffey -Document 'Expedite' in the subject line -Include call transcription if is a wav file	Medicaid <i>after</i> 5 pm est M-F and on weekend	MCDEpedite@humana.com -Include call transcription if is a WAV file	Puerto Rico	G&ApuertoRicoTeam@humana.com	Tricare	Cindy Petrous
If...	Then...												
Medicare	ExpediteLineTeamLSC@humana.com												
Medicaid <i>before</i> 5 pm est M-F	MedicareGARightFax@humana.com -CC Mary Eagan and Steve Coffey -Document 'Expedite' in the subject line -Include call transcription if is a wav file												
Medicaid <i>after</i> 5 pm est M-F and on weekend	MCDEpedite@humana.com -Include call transcription if is a WAV file												
Puerto Rico	G&ApuertoRicoTeam@humana.com												
Tricare	Cindy Petrous												

Indiana – Appeal (Grievance) First Level – HMO/HMO-POS/PPO/Indemnity Table of Contents

Indiana – Appeal (Grievance) First Level – HMO/HMO-POS/PPO/Indemnity.....	2
When to Use the Process.....	2
Definitions.....	2
Who Can Submit the Request?.....	2
In What Manner May the Request be Submitted?.....	2
Timeframe to Submit Request.....	3
Is Acknowledgement of the Request Required?	3
Who Must Receive Acknowledgement?.....	3
Decision Timeframe	3
Is Extension of the Decision Timeframe Permitted?	4
Reviewer Requirements.....	4
Decision Notification Requirements Method	4
Decision Notification Content Requirements.....	4
Who Must Receive the Decision Notification?	5

Indiana – Appeal (Grievance) First Level – HMO/HMO-POS/PPO/Indemnity

When to Use the Process

An **appeal** regarding an **adverse determination**.

Definitions

Adverse Determination – a denial, reduction, termination of, or failure to provide or make payment:

- In whole or in part for a benefit (Example: Applying the plan provisions and paying less than the total amount of expense submitted for a deductible, coinsurance or co-payment) (1)
- Based on eligibility to participate in the plan (when a claim or appeal is made) (1)
- Based on rescission of coverage (1)

Appeal – a request for reconsideration of an adverse determination. (2)

Who Can Submit the Request?

The member. Anyone other than the member must have authorization. (1) (3) & (5)

Request for Authorization Letter & Form: MED AOR Letters (2)

In What Manner May the Request be Submitted?

Oral, written, or electronic. (1) (3) & (4)

Continued on next page

1 ERISA/Federal Requirement
2 Business Decision
3 URAC Standard
4 State Specific Requirement
5 NCQA Standard
6 NAIC Standard

First Level – HMO/HMO-POS/PPO/Indemnity, Continued

Timeframe to Submit Request 180 calendar days (from receipt of the **adverse determination**). (1) (3) & (5)

Is Acknowledgement of the Request Required? **Step Therapy Protocol** exception cases: No (2)

HMO/HMO-POS: Yes, within 3 business days of receipt (4), except cases involving Step Therapy Protocol exception requests (2).

PPO/Indemnity: Yes, within 5 business days of receipt, except cases involving Step Therapy Protocol exception requests. (2)

Use this link: MED_G ACK

Who Must Receive Acknowledgement? Appellant as stated in the Who Can Submit the Request? section. (2)

Decision Timeframe **All Step Therapy Protocol exception** cases, not later than 3 business days from receipt. (4)

All pre-service and concurrent care adverse determinations, except cases involving Step Therapy Protocol exception requests, not later than 15 calendar days from receipt. (1) (3) (4) & (5)

All post-service adverse determinations, except cases involving Step Therapy Protocol exception requests, not later than 20 business days from receipt. (1) (4) & (5)

Continued on next page

[Return to Table of Contents](#)

First Level – HMO/HMO-POS/PPO/Indemnity, Continued

Is Extension of the Decision Timeframe Permitted?

Not permitted. (1) & (3)

Reviewer Requirements

Medical necessity or experimental/investigational adverse determinations, the reviewer must:

- Hold an active, unrestricted medical license
- Be from the same or similar specialty who typically treats the medical condition or provides the treatment in question (1) & (3)

All adverse determinations, the reviewer must:

- Not have participated in the initial decision (1) (3) & (5)
 - Not be a subordinate of the individual who made the initial decision. (1) (3) & (5)
-

Decision Notification Requirements Method

Within 5 business days of the decision, written or electronic notice (must ensure documents received and provide paper copy upon request), **except** cases involving Step Therapy Protocol, written notice must be sent immediately. (1) (2) (3) & (4)

Decision Notification Content Requirements

All upholds or partial overturns:

- The right to request a panel review
- Procedures to initiate the panel review
- The DOI website address
- Name, department, address & phone number of the health plan's representative to contact for more information about decision and appeal rights.

Use this link: MED IN RES 09 Panel Rights (1) (3) (4) & (5)

Overturns, use this link: MED _G RES OT (1) (3) & (5)

Continued on next page

First Level – HMO/HMO-POS/PPO/Indemnity, Continued

**Who Must
Receive the
Decision
Notification?**

Step Therapy Protocol exception appeals (4):

- The member or their authorized representative (non-provider)
- The provider

All other appeals:

- **Member appeals:** the member and prescriber for pharmacy appeals
- **Authorized Representative appeals** (non-provider): the authorized representative and prescriber for pharmacy appeals
- **Provider appeals** (with authorization):
 - The provider and prescriber for pharmacy appeals, if different.
 - The member or their authorized representative (non-provider)

(1) (2) (3) & (5)

[Return to Table of Contents](#)

Indiana – Appeal (Grievance) Second Level – HMO/HMO-POS/PPO/Indemnity Table of Contents

Indiana – Appeal (Grievance) Second Level – HMO/HMO-POS/PPO/Indemnity.....	2
When to Use the Process.....	2
Definitions.....	2
Who Can Submit the Request?.....	2
In What Manner May the Request be Submitted?.....	2
Timeframe to Submit Request.....	3
Is Acknowledgement of the Request Required?	3
Who Must Receive Acknowledgement?.....	3
Is Panel Review Notification Required?.....	3
Decision Timeframe	3
Is Extension of the Decision Timeframe Permitted?	3
Reviewer Requirements.....	4
Decision Notification Requirements Method.....	4
Decision Notification Content Requirements MN/EI	4
Decision Notification Content Requirements NSA	5
Decision Notification Content Requirements All Other	5
Who Must Receive the Decision Notification?	5

Indiana – Appeal (Grievance) Second Level – HMO/HMO-POS/PPO/Indemnity

When to Use the Process

An **appeal** regarding an **adverse determination**.

Definitions

Adverse Determination – a denial, reduction, termination of, or failure to provide or make payment:

- In whole or in part for a benefit (Example: Applying the plan provisions and paying less than the total amount of expense submitted for a deductible, coinsurance or co-payment) (1)
- Based on eligibility to participate in the plan (when a claim or appeal is made) (1)
- Based on rescission of coverage (1)

Appeal – a request for reconsideration of an adverse determination. (2)

Who Can Submit the Request?

The member. Anyone other than the member must have authorization. (1) (3) & (5)

Request for Authorization Letter & Form: MED AOR Letters (2)

In What Manner May the Request be Submitted?

Oral, written, or electronic. (1) (3) & (4)

Continued on next page

1 ERISA/Federal Requirement
2 Business Decision
3 URAC Standard
4 State Specific Requirement
5 NCQA Standard
6 NAIC Standard

Second Level – HMO/HMO-POS/PPO/Indemnity, Continued

Timeframe to Submit Request

Not specified. (4)

Is Acknowledgement of the Request Required?

HMO/HMO-POS: Yes, within 3 business days of receipt. (4)

PPO/Indemnity: Yes, within 5 business days of receipt. (2)

Use this link: MED _G ACK Panel Attend

Who Must Receive Acknowledgement?

Appellant as stated in the Who Can Submit the Request? section. (2)

Is Panel Review Notification Required?

Yes, at least 72 hours before the panel meeting. (4) Notice must include member's right to:

- Appear in person before panel at a location convenient to the member during normal business hours (4)
- Communicate with the panel if unable to appear in person. (4)

Use this link: MED Panel Communications (2) & (4)

Decision Timeframe

All pre-service and concurrent care adverse determinations, not later than 15 calendar days from receipt. (1) (3) (4) & (5)

All post-service adverse determinations, not later than 30 calendar days from receipt. (1) (4) & (5)

Is Extension of the Decision Timeframe Permitted?

Not permitted. (1) (3) & (4)

Continued on next page

Second Level – HMO/HMO-POS/PPO/Indemnity, Continued

Reviewer Requirements

Medical necessity or experimental/investigational adverse determinations, at least one **panel reviewer** must:

- Hold an active, unrestricted medical license;
- Be from the same or similar specialty who typically treats the medical condition or provides the treatment in question (1) & (3)
- Be in the same profession as the treating provider (4)

All adverse determinations, the **panel reviewers** must:

- Not have participated in the initial adverse decision or prior appeal decision (1) (3) & (5)
 - Not be a subordinate of the individual who made the initial adverse decision or prior appeal decision (1) (3) & (5)
 - Not have a direct business relationship with the member or the provider at issue (4)
-

Decision Notification Requirements Method

Within 5 business days of the decision, written or electronic notice (must ensure documents received and provide paper copy upon request). (1) (2) (3) & (4)

Decision Notification Content Requirements MN/EI

All medical necessity, experimental/investigational upholds or partial overturns, notice must include:

- The right to request an external review by an IRO
- Procedures to initiate the IRO review
- The DOI website address
- Name, department, address & phone number of the health plan's representative to contact for more information about decision and appeal rights (4)

Use this link: MED IN RES 12 IRO Rights (1) (3) (4) & (5)

Continued on next page

[Return to Table of Contents](#)

Indiana – Appeal (Grievance) Second Level – HMO/HMO-POS/PPO/Indemnity, Continued

Decision Notification Content Requirements NSA

All upholds or partial overturns for any claims in scope for NSA, with a DOS on or after 1/1/2022, that do not fit into the MN/EI section above for:

- Any denial based on medical judgment (including contractual)
- All other contractual denials (not based on medical judgment)

Notice must include:

- Notice of the right to obtain an Federal External review (1)
- Procedures for requesting a Federal External Review

Use this link: MED _G RES 09 NSA

Examples of adverse determinations based on NSA compliance are included in the following document: Federal External Review Examples

Decision Notification Content Requirements All Other

All other upholds or partial overturns, use this link: MED _G RES 10 Panel (1) (3) & (5)

Overturns, use this link: MED _G RES Panel OT (1) (3) & (5)

Who Must Receive the Decision Notification?

Step Therapy Protocol exception appeals (4):

- The member or their authorized representative (non-provider)
- The provider

All other appeals:

- **Member appeals:** the member
- **Authorized Representative appeals** (non-provider): the authorized representative
- **Provider appeals** (with authorization):
 - The provider
 - The member or their authorized representative (non-provider)

(1) (2) (3) & (5)

[Return to Table of Contents](#)



- 1 ERISA/Federal Requirement
- 2 Business Decision
- 3 URAC Standard
- 4 State Specific Requirement
- 5 NCQA Standard
- 6 NAIC Standard

Indiana – Expedited Appeal (Grievance) First Level – HMO/HMO-POS/PPO/Indemnity Table of Contents

Indiana – Expedited Appeal (Grievance) First Level – HMO/HMO-POS/PPO/Indemnity...	2
General Information	2
When to Use the Process.....	2
Definitions.....	2
Who Can Submit the Request?.....	2
In What Manner May the Request be Submitted?.....	2
Timeframe to Submit Request.....	3
Is Acknowledgement of the Request Required?	3
Who Must Receive Acknowledgement?.....	3
Decision Timeframe	3
Is Extension of the Decision Timeframe Permitted?	3
Reviewer Requirements.....	4
Decision Notification Requirements Method.....	4
Decision Notification Content Requirements.....	4
Who Must Receive the Decision Notification?	5

Indiana – Expedited Appeal (Grievance) First Level – HMO/HMO-POS/PPO/Indemnity

General Information The requirements outlined below reflect the most stringent rule between federal (i.e., ERISA) and every state law.

When to Use the Process An **appeal** of an adverse determination involving **urgent care**.

Definitions **Urgent care** – treatment or services, that if delayed, could seriously jeopardize the life or health of the member, their ability to regain maximum function, or in the opinion of the treating physician (oral or written) would subject the member to severe pain that cannot be adequately managed without the treatment. (1) (3) & (5)

Who Can Submit the Request? The member or provider. Anyone other than the member or provider must have authorization. (1) (2) (3) & (5)

Request for Authorization Letter & Form: MED AOR Letters (2)

In What Manner May the Request be Submitted? Oral, written, or electronic. (1) (3) & (4)

Continued on next page

First Level – HMO/HMO-POS/PPO/Indemnity, Continued

Timeframe to Submit Request

Not applicable.

Is Acknowledgement of the Request Required?

Yes, oral acknowledgement is required not later than 24 hours of receipt. (2)

Who Must Receive Acknowledgement?

Appellant as stated in the Who Can Submit the Request? section. (2)

Decision Timeframe

All Step Therapy Protocol exception cases, not later than 1 business day from receipt. (4)

All others, not later than 48 hours of receipt of all necessary information, not to exceed 72 hours of receipt of the appeal. (1) (3) (4) & (5)

Is Extension of the Decision Timeframe Permitted?

Not permitted. (1) (3) & (4)

Continued on next page

[Return to Table of Contents](#)

First Level – HMO/HMO-POS/PPO/Indemnity, Continued

Reviewer Requirements

Medical necessity or experimental/investigational adverse determinations, the reviewer must:

- Hold an active, unrestricted medical license
- Be from the same or similar specialty who typically treats the medical condition or provides the treatment in question (1) & (3)

All adverse determinations, the reviewer must:

- Not have participated in the initial decision (1) (3) & (5)
 - Not be a subordinate of the individual who made the initial decision. (1) (3) & (5)
-

Decision Notification Requirements Method

Oral, written, or electronic notice (must ensure documents are received and provide paper copy upon request). If provided orally, written notice must be sent within 3 calendar days, **except** cases involving Step Therapy Protocol, written notice must be sent immediately. (1) (3) (4) & (5)

Note: Pharmacy appeals, oral and written notification is required. (3)

Decision Notification Content Requirements

All medical necessity, experimental/investigational upholds or partial overturns:

- The right to request an external review by an IRO
- Procedures to initiate the IRO review
- The DOI website address
- Name, department, address & phone number of the health plan's representative to contact for more information about decision and appeal rights (4)

Use this link: MED IN RES 09 IRO Rights (1) (3) (4) & (5)

All other upholds or partial overturns, use this link: MED _G RES 04 (1) (3) & (5)

Overturns, use this link: MED _G RES OT (1) (3) & (5)

Continued on next page

Indiana – Expedited Appeal (Grievance) First Level – HMO/HMO-POS/PPO/Indemnity, Continued

Who Must Receive the Decision Notification?

Step Therapy Protocol exception appeals (4):

- The member or their authorized representative (non-provider)
- The provider/prescriber

All other appeals:

- **Member appeals:** the member and prescriber for pharmacy appeals
- **Authorized Representative appeals** (non-provider): the authorized representative and prescriber for pharmacy appeals
- **Provider appeals** (with authorization): The provider and prescriber for pharmacy appeals, if different

(1) (2) (3) & (5)

[Return to Table of Contents](#)

Indiana – Grievance First Level – All Products Table of Contents

Indiana – Grievance First Level – All Products.....	2
When to Use the Process.....	2
Definitions.....	2
Who Can Submit the Request?.....	2
In What Manner May the Request be Submitted?.....	2
Timeframe to Submit Request.....	3
Is Acknowledgement of the Request Required?	3
Who Must Receive Acknowledgement?.....	3
Resolution Timeframe.....	3
Is Extension of the Resolution Timeframe Permitted?.....	3
Reviewer Requirements.....	4
Resolution Notification Requirements Method	4
Resolution Notification Content Requirements	4
Who Must Receive the Resolution Notification?	4

Indiana – Grievance First Level – All Products

When to Use the Process

For the resolution of **grievances** – this **does not** include issues related to a claim or service denial; refer to the appropriate Appeal process. (2)

Follow appeal process for claim practices and adverse determinations underlined in the Definition of Grievance. (2)

Definitions

Grievance – Any dissatisfaction expressed by (or on behalf of) a member about:

- A decision that the service is not medically necessary, experimental and investigational;
 - The availability, delivery, appropriateness, or quality of services;
 - Claims payment or handling;
 - Matters pertaining to the contractual relationship;
 - Based on rescission of coverage;
 - A decision concerning a prior authorization request (4)
-

Who Can Submit the Request?

The member. Anyone other than the member must have authorization. (2) & (4)

Request for Authorization Letter & Form: MED AOR Letters (2)

In What Manner May the Request be Submitted?

Oral, written, or electronic. (2) & (4)

Continued on next page

First Level – All Products, Continued

Timeframe to Submit Request

Not specified.

Is Acknowledgement of the Request Required?

HMO/HMO-POS: Yes, within 3 business days of receipt. (4)

PPO/Indemnity: Yes, within 5 business days of receipt. (2)

Use this link: MED _G ACK (2) & (4)

Who Must Receive Acknowledgement?

Grievant as stated in the Who Can Submit the Request? section. (2)

Resolution Timeframe

All grievances, not later than 20 business days from receipt. (4)

Is Extension of the Resolution Timeframe Permitted?

Yes. May be extended for up to 10 business days if written notice of delay is sent before end of the initial 20 business days.

Use this link: Extension Letters (4)

Continued on next page

[Return to Table of Contents](#)

First Level – All Products, Continued

Reviewer Requirements

The reviewer must:

- Not have participated in the initial decision (2)
 - Not be a subordinate of the individual who made the initial decision. (2)
-

Resolution Notification Requirements Method

Within 5 business days of the decision, written or electronic notice (must ensure documents received and provide paper copy upon request). (2) & (4)

Resolution Notification Content Requirements

Notice must include:

- The right to request a panel review
- Procedures to initiate the panel review
- Name, department, address & phone number of the health plan's representative to contact for more information about decision and appeal rights.

Use this link: MED _G RES Complaint - Grv (4)

Who Must Receive the Resolution Notification?

- **Member grievances:** the member
 - **Authorized Representative grievances** (non-provider): the authorized representative
 - **Provider grievances** (with authorization):
 - The provider
 - The member or their authorized representative (non-provider)
- (2) & (4)
-

[Return to Table of Contents](#)

Indiana – Grievance Second Level – All Products Table of Contents

Indiana –Grievance Second Level – All Products	2
When to Use the Process.....	2
Definitions.....	2
Who Can Submit the Request?.....	2
In What Manner May the Request be Submitted?.....	2
Timeframe to Submit Request.....	3
Is Acknowledgement of the Request Required?	3
Who Must Receive Acknowledgement?.....	3
Is Panel Review Notification Required?.....	3
Resolution Timeframe.....	3
Is Extension of the Resolution Timeframe Permitted?.....	3
Reviewer Requirements.....	4
Resolution Notification Requirements Method	4
Resolution Notification Content Requirements	4
Who Must Receive the Resolution Notification?	4

Indiana –Grievance Second Level – All Products

When to Use the Process

For the resolution of **grievances** – this **does not** include issues related to a claim or service denial; refer to the appropriate Appeal process. (2)

Follow appeal process for claim practices and adverse determinations underlined in the Definition of Grievance. (2)

Definitions

Grievance – Any dissatisfaction expressed by (or on behalf of) a member about:

- A decision that the service is not medically necessary, experimental and investigational;
 - The availability, delivery, appropriateness, or quality of services;
 - Claims payment or handling;
 - Matters pertaining to the contractual relationship;
 - Based on rescission of coverage;
 - A decision concerning a prior authorization request (4)
-

Who Can Submit the Request?

The member. Anyone other than the member must have authorization. (2) & (4)

Request for Authorization Letter & Form: MED AOR Letters (2)

In What Manner May the Request be Submitted?

Oral, written, or electronic. (2) & (4)

Continued on next page

Second Level – All Products, Continued

Timeframe to Submit Request

Not specified.

Is Acknowledgement of the Request Required?

HMO/HMO-POS: Yes, within 3 business days of receipt. (4)

PPO/Indemnity: Yes, within 5 business days of receipt. (2)

Use this link: MED _G ACK Panel Attend (2) & (4)

Who Must Receive Acknowledgement?

Grievant as stated in the Who Can Submit the Request? section. (2) & (4)

Is Panel Review Notification Required?

Yes, at least 72 hours before the panel meeting. (4) Notice must include member's right to:

- Appear in person before panel at a location convenient to the member during normal business hours (4)
- Communicate with the panel if unable to appear in person. (4)

Use this link: MED Panel Communications (2) & (4)

Resolution Timeframe

All grievances, not later than 45 business days from receipt. (4)

Is Extension of the Resolution Timeframe Permitted?

Not permitted. (4)

Continued on next page

[Return to Table of Contents](#)

Second Level – All Products, Continued

Reviewer Requirements

The panel:

- Must include a minimum of 3 voting members unless otherwise required by the state (2)
 - May include internal Humana associates from various departments throughout the company and/or external non-Humana associates (2)
 - Reviewers must:
 - Not have participated in the initial decision (2)
 - Not be a subordinate of the individual who made the initial decision (2)
 - Must include at least one member who:
 - Is knowledgeable of the medical condition, procedure, or treatment at issue (4)
 - Is in the same profession as the treating provider (4)
 - Does not have a direct business relationship with the member or provider at issue (4)
-

Resolution Notification Requirements Method

Within 5 business days of the decision, written or electronic notice (must ensure documents received and provide paper copy upon request). (2) & (4)

Resolution Notification Content Requirements

Notice must include name, department, address & phone number of the health plan's representative to contact for more information about decision and appeal rights.
Use this link: MED _G RES Panel Grv (4)

Who Must Receive the Resolution Notification?

- **Member grievances:** the member
 - **Authorized Representative grievances** (non-provider): the authorized representative
 - **Provider grievances** (with authorization):
 - The provider
 - The member or their authorized representative (non-provider)
- (2) & (4)
-