



Manual: IU Health Plans  
 Department:  
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# Health Plans

## Indiana University Health Plans, Inc.

Medicare Advantage    Medicaid     Commercial     Exchange

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### IU Health Plans Appeals Policy

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#### I. Purpose

To provide a process for identifying investigating and responding to member Administrative and Clinical Grievances and Appeals in an appropriate and timely manner.

#### II. Scope

Administrative Grievances/Appeals  
 Clinical Grievance/Appeals

#### III. Definitions

**Appeal:** An oral or written request from a covered person, authorized representative or provider to change a previous decision made by IU Health Plans that was unresolved to the covered person’s or provider’s satisfaction at the complaint .

**Authorized Representative** – An individual who the Covered Person has authorized in writing to represent or act on their behalf with regards to a claim or an appeal. An assignment of benefits does not constitute a written authorization for a Provider to act as an Authorized Representative of a Covered Person.

Pre-service grievance / appeal – A request to change an adverse determination made by the organization for care or service that has not been provided to the member.

Post-service grievance /appeal (First Level Post-Service Appeal and Second Level post-service Appeal): - A request to change an adverse determination made by the organization for care or service already rendered.

Urgent care/expedited appeal – A request to change an adverse determination made by the organization for care or service that has not been provided or care and service that are actively ongoing and to which the application of the time periods for making pre-service or post-service appeal decisions could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function if the care or service is not received.

#### IV. Policy Statements

Members or authorized member representatives are directed to contact the IU Health Plans Customer Solution Center (CSC) to make suggestions, request information assistance or to express dissatisfaction. IU Health Plans will organize a comprehensive review and resolution of a member's dispute regarding: the availability, delivery, appropriateness, medical necessity, or quality of health care services; the payment of a claim; or matters pertaining to the contractual relationship between the enrollee and the Plan. The member should have a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. This policy is available upon request to any member, provider or practitioner.

All Grievance/Appeal records shall contain: (1) The name of the member, provider and /or facility rendering service, (2) copies of all correspondence from the member, provider, or facility rendering service and the organization regarding the appeal, (3) Dates of appeal reviews, documentation of actions taken, and final resolution, and (4) Minutes or transcripts of appeal proceedings (if any).

## **V. Procedures**

### **A. Pre-service Appeals**

1. At the time a Pre-Service Appeal is received, the Appeal and Grievance Representative date stamps and documents the details of the Appeal in the internal tracking system.
2. If the requesting party is someone other than the member, obtains the necessary information and signature of the member designating an Authorized Representative to act on his/her behalf during the Appeal process.
3. The member or authorized representative is allowed at least 180 days after notification of the denial to file an appeal.
4. A Letter is sent to the Member within two (2) business days of receipt of the Appeal. The letter:
  - a. Acknowledges the receipt of the member's Appeal
  - b. Offers the member the opportunity to be represented by someone of their choosing (including a practitioner, provider or member representative) as long as the designation is made in writing; and
  - c. Advises the member of the following options:
    - i. Members and/or their designated representative may request to appear before the Appeal Panel;
    - ii. Members and/or their designated representative may submit oral or written comments, documents, or other information;
    - iii. Members and/or their designated representative may request copies of all documents relevant to the member's Appeal;
    - iv. Members and/or designated representatives who cannot appear in person at the hearing may communicate with the Appeals Panel via conference calling.
    - v. When a member and/or the designated representative does not wish to participate in a hearing, the Appeal Panel will review the appeal documentation and render a decision.

5. The Appeal and Grievance Representative contacts the appropriate IU Health Plans (Plan) personnel or the Practitioner's office for any additional information pertinent to the Appeal in order for the Plan to conduct a full investigation of the substance of the appeal.
6. The Appeal and Grievance Representative will forward the complete case file to the appropriate reviewer(s) requesting a written response within five (5) business days.
7. The member will be provided with a minimum of 72 hours-notice of the scheduled Appeal Panel hearing when applicable. The member has the right to waive participation in a hearing.
8. No members of the Appeal Panel may be involved in any previous determination or be the subordinates of any person involved in the initial determination.
9. Appeal Panel members may be Representatives of any of the following IU Health Plans departments as appropriate:
  - a. Medical Director/Associate Medical Director
  - b. Medical Management
  - c. Member Services
  - d. Quality Management
  - e. Claims
  - f. Marketing
  - g. Provider Relations
  - h. Pharmacy
10. For Appeals involving any clinical issues including Appeals with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the IU Health Plans Medical Director shall consult a Credentialed Board Certified specialist of the same or similar specialty as to the clinical question-during the review of the Appeal. The specialist:
  - a. Shall have knowledge of the medical condition, procedure or treatment at issue;
  - b. Shall be in the same licensed profession as the practitioner who proposed, refused or delivered the health care procedure, treatment or service;
  - c. Is not involved in the matter giving rise to the Appeal or the previous grievance or processes; and
  - d. Shall not have a direct business relationship with the Covered Person (enrollee) or the practitioner who previously recommended the health care procedure, treatment or service giving rise to the Appeal.
11. The Appeal will be completed and the member notified of the decision within 20 business days of the request. Notification includes:
  - a. The decision, in clear terms, with the benefits or clinical rationale;
  - b. A description of the next level of appeal, (External Review by Independent Review Organization and/or civil action under ERISA 502(a)) and any relevant written instructions;
  - c. Notice that civil action under ERISA 502(a) does not apply to employees of Church Groups or Federal, State, and Local Government.
  - d. A list of titles and qualifications of individuals participating in the review of the Appeal;
  - e. A statement of the pertinent facts of the Appeal;
  - f. A reference to the provisions that support the decision such as the Group Service Agreement or contract;

- g. If applicable, a copy of or a statement that an internal rule, guideline or protocol was relied upon and is available upon request;
      - h. Statement of any additional information that could be helpful in the outcome of the Appeal; and
      - i. Instructions for requesting a written statement of the clinical rationale and review criteria for cases involving a denial of medical services.
      - j. Notification about further appeal rights
12. The Appeal and Grievance Representative will document the substance of the Appeal, including all actions taken during the review, appeal hearing, and all aspects of clinical care involved in the case.

## **B. Urgent Care Appeal/Expedited Appeal**

1. An urgent care appeal/expedited appeal will be provided for requests for review of an adverse determination related to an illness, a disease, a condition, an injury or a disability that would seriously jeopardize the Covered Person's:
  - a. Life or health;
  - b. Ability to reach and maintain maximum function; or
  - c. Requires medical service within 48 to 72 hours.
2. Urgent Care Appeals may include Concurrent Care reviews as appropriate. Concurrent Care reviews concern an adverse determination of a request for benefits affecting an ongoing course of treatment taking place over a period of time or a number of treatments. Urgent Care Appeals/Expedited Appeals must be offered 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 a facility.
3. Upon written or oral receipt of an urgent care appeal/expedited appeal from a member or a member designated authorized representative acting on behalf of the member, the Appeal and Grievance Representative:
  - a. Contacts the Clinical Appeals Manager for determination that a request meets the criteria for an urgent care appeal/expedited appeal.
  - b. Documents the urgent care appeal/expedited appeal into the internal tracking system; and
  - c. Makes a copy and forwards it to the Clinical Appeals Manager.
  - d. Sends written confirmation of Plan decision to the member, member representative, or practitioner filing the appeal.
4. The Clinical Appeals Manager:
  - a. Documents the urgent care appeal/expedited appeal into the Medical Management appeal review tracking system;
  - b. Collects and refers all documentation to a Medical Director/Associate Medical Director not involved in the initial decision nor a subordinate of that individual, who confers with appropriate specialists as indicated, investigates all submitted information, and makes a decision on the urgent care appeal/expedited appeal;
  - c. Notifies the member, member representative, or practitioner verbally of the Medical Director/Associate Medical Director's decision as expeditiously as the medical condition warrants, but no more than seventy-two (72) hours from the receipt of the urgent care appeal/expedited appeal;
  - d. Within (1) business day of providing verbal notification of the decision, returns the urgent care appeal/expedited appeal case file to the Appeal and Grievance Representative for written confirmation of the Plan's decision to the member,

- e. member representative, or practitioner and
  - e. Updates the Medical Management appeal tracking system.
5. Notification Letters include:
- a. The decision, in clear terms, with the benefits or clinical rationale;
  - b. A description of the next level of appeal, (External Review by Independent Review Organization and/or civil action under ERISA 502(a)) and any relevant written instructions;
  - c. Notice that civil action under ERISA 502(a) does not apply to employees of Church Groups or Federal, State, and Local Government.
  - d. A list of titles and qualifications of individuals participating in the review of the Appeal;
  - e. A statement of the pertinent facts of the Appeal;
  - f. A reference to the provisions that support the decision such as the Group Service Agreement or contract;
  - g. If applicable, a copy of or a statement that an internal rule, guideline or protocol was relied upon and is available upon request;
  - h. Statement of any additional information that could be helpful in the outcome of the Appeal; and
  - i. Instructions for requesting a written statement of the clinical rationale and review criteria for cases involving a denial of medical services.
  - j. Notification about further appeal rights.

### **C. Post-Service Grievances (First Level Post-Service Appeal)**

1. At the time a Post-Service Grievance (First Level Post-Service Appeal) is received, the Appeal and Grievance Representative notifies the member in writing within three (3) business days that his/her Post-Service Grievance (First Level Post-Service Appeal) has been received;
2. If the requesting party is someone other than the member, obtains the necessary information and signature of the member designating an Authorized Representative to act on his/her behalf during the Grievance (First Level Post-Service Appeal) process.
3. Provides the member or designated member representative with information concerning the review process;
4. Provides the member or designated member representative with the name and direct phone number of the IU Health Plans Representative who will be handling their review;
5. Enters the Post-Service Grievance (First Level Post-Service Appeal) into the internal tracking system and does the following:
  - a. Contacts the appropriate IU Health Plans(Plan) personnel or the Practitioner's office for any additional information pertinent to the Post-Service Grievance (First Level Post-Service Appeal);
  - b. Sends internal tracking information and all additional documentation received from the Member and/or providers to appropriate IU Health Plans personnel for review of the case file requesting a response within five (5) business days;
  - c. Submits the Post-Service Grievance (First Level Post-Service Appeal), with all available, relevant documentation that has been acquired, for a decision, to an

individual not involved in any previous determination; this usually is reviewed by the Associated Medical Director or the Medical Director for a clinical Grievance, or the Director of Member Services for a non-clinical Grievance. Neither individual may have been involved in any previous determination.

- d. Documents the substance of the Post-Service Grievance (First Level Post-Service Appeal), including all actions taken during the review and all aspects of clinical care involved in the case.
  - e. Sends decision letter to member or designated representative.
6. The Post-Service Grievance (First Level Post-Service Appeal) will be completed and the member notified of the decision within twenty (20) business days of the request
  7. Notification Letters include:
    - a. The decision, in clear terms, with the benefits or clinical rationale;
    - b. A description of the next level of appeal, (External Review by Independent Review Organization and/or civil action under ERISA 502(a)) and any relevant written instructions;
    - c. Notice that civil action under ERISA 502(a) does not apply to employees of Church Groups or Federal, State, and Local Government.
    - d. A list of titles and qualifications of individuals participating in the review of the Appeal;
    - e. A statement of the pertinent facts of the Appeal;
    - f. A reference to the provisions that support the decision such as the Group Service Agreement or contract;
    - g. If applicable, a copy of or a statement that an internal rule, guideline or protocol was relied upon and is available upon request;
    - h. Statement of any additional information that could be helpful in the outcome of the Appeal; and
    - i. Instructions for requesting a written statement of the clinical rationale and review criteria for cases involving a denial of medical services.
    - j. Notification about further appeal rights.
  8. The Appeal and Grievance Representative will document the substance of the Post-Service Grievance (First Level Post-Service Appeal), including all actions taken during the review and all aspects of clinical care involved in the case and close the file.

#### **D. Post-Service Appeals (Post Service Second Level Appeal)**

1. When the Member requests a Post-Service Appeal (Post Service Second Level Appeal), the plan shall investigate all submitted information and document the substance of the appeal and any actions taken including aspects of clinical care involved in the internal tracking system.
2. If the requesting party is someone other than the member, the IU Health Plans Appeal Representative obtains the necessary information as well as the member's designation of an Authorized Representative to act on his/her behalf during the Appeal process.

3. The member or authorized representative is allowed at least 180 days after notification of the denial to file an appeal.
4. A letter is sent to the member/member authorized representative from the Appeal Analyst, advising the member/member representative that the review will proceed to the Appeal level. The letter:
  - a. Provides the member/member Representative with information concerning the Appeal process;
  - b. Advises the member/Member Representative of their right to request copies of all documents relevant to the member's appeal;
  - c. Offers the member the opportunity to be represented by someone of their choosing (including a practitioner or member representative) as long as the person is designated in writing; and
  - d. Advises the member of the following options allowed:
    - i. Members/member Representatives may request to appear before the Appeal Panel;
    - ii. Members/member Representatives may submit oral or written comments, documents, or other information;
    - iii. Members/member Representatives who cannot appear in person at the hearing may communicate with the Appeal Panel via conference calling.
    - iv. When a member/member representative does not wish to attend a hearing, the appropriate Appeal Panel will review the Appeal documentation and render a decision.
5. No members of the Appeal Panel may be involved in any previous determination or be the subordinates of any person involved in the initial determination.
6. Appeal Panel members may be Representatives of any of the following IU Health Plans departments as appropriate:
  - a. Medical Director/Associate Medical Director
  - b. Medical Management
  - c. Member Services
  - d. Quality Management
  - e. Claims
  - f. Marketing
  - g. Provider Relations
  - h. Pharmacy
7. For Appeals involving any clinical issues including Appeals with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the IU Health Plans Medical Director/Associate Medical Director shall consult a Board Certified specialist of the same or similar specialty as to the clinical question-during the review of the Appeal. The specialist:
  - a. Shall have knowledge of the medical condition, procedure or treatment at issue;

- b. Shall be in the same licensed profession as the practitioner who proposed, refused or delivered the health care procedure, treatment or service;
  - c. Is not involved in the matter giving rise to the Appeal or the previous grievance process; and
  - d. Shall not have a direct business relationship with the Covered Person (enrollee) or the practitioner who previously recommended the health care procedure, treatment or service-giving rise to the Grievance/Appeal.
8. Letters to the member/Member Representative of the Appeal decision shall include the following elements, when applicable:
- a. The decision, in clear terms, with the benefits or clinical rationale;
  - b. A description of the next level of appeal, (External Review by Independent Review Organization and/or civil action under ERISA 502(a)) and any relevant written instructions as acknowledged in communications to members or authorized representative.
  - c. Notice that civil action under ERISA 502(a) does not apply to employees of Church Groups or Federal, State, and Local Government.
  - d. A list of titles and qualifications of individuals participating in the review of the Appeal;
  - e. A statement of the pertinent facts of the Appeal;
  - f. A reference to the provisions that support the decision such as the Group Service Agreement or contract;
  - g. If applicable, a copy of or a statement that an internal rule, guideline or protocol was relied upon and is available upon request;
  - h. Statement of any additional information that could be helpful in the outcome of the Appeal; and
  - i. Instructions for requesting a written statement of the clinical rationale and review criteria for cases involving a denial of medical services.
  - j. Notification to the member about further appeal rights.
9. The Post-Service Appeal (Post Service Second Level Appeal), review will be completed and the member and member Representative (if applicable) notified of the decision no later than thirty (30) days from receipt of the Appeal.
10. The Appeal and Grievance Representative will document the substance of the Appeal, including all actions taken during the review, appeal hearing, and all aspects of clinical care involved in the case and close the appeal file.

#### **E. External Review**

- 1. A request for an independent, external review of the final adverse determination that was made by the organization through its internal appeal process.
- 2. If a member is not satisfied with the Appeal decision, the member may contact the plan to proceed to the External Review process. The request for External Review must be received within 120 calendar days of the receipt of the Plan's decision letter regarding the appeal.

3. If an External Review is requested by someone other than the member, the member is contacted to obtain the necessary information and signature on the Designation of Representation form to act on the member's behalf during the External Appeal review process.
4. The Plan will provide an Expedited Appeal for a Pre-Service Appeal related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the enrollee's
  - a. Life or health; or
  - b. Ability to reach maximum function or in which the External Review Organization must render a determination within 72 hours after the Appeal is filed.
5. The member is eligible for External Review if their Appeal was for:
  - a. An adverse utilization review determination;
  - b. An adverse determination of Medical Necessity; or
  - c. A determination that a proposed service is Experimental or Investigational (of a service proposed by the treating physician).
6. The IRO will rely on appropriate clinical expertise, will not have any direct financial interest in the health plan or in the outcome of the external appeal, and may not have been involved in the original determination under appeal.
7. Costs associated with the External Review process will be paid by the Plan.
8. Upon receipt of the External Review request by the Appeal and Grievance Representative, the External Review is date-stamped and substance and actions taken are documented in the internal tracking system.
9. The Appeal and Grievance Representative will forward a copy of all documentation to the Independent Review Organization for their decision.
10. The Appeal and Grievance Representative will select the IRO (Independent Review Organization) to conduct the External Review from the Independent Review Organization Rotation Assignment List on the Indiana Department of Insurance website: [www.in.gov/idoi](http://www.in.gov/idoi). The IRO selection will be done sequentially without repeating review organizations until each organization on the list has been selected.
11. The Independent Review Organization has seventy-two (72) hours to reach a determination on Urgent/Expedited Appeals and fifteen (15) days to reach a determination on standard Appeals. The Independent Review Organization will notify the Plan and the enrollee within twenty-four (24) hours of reaching the determination for an Urgent/Expedited Appeal and within seventy-two (72) hours of reaching the determination for a standard Appeal.
12. Once the Appeal Analyst receives a copy of the determination from the Independent Review Organization, the appropriate action is taken and a copy of the documentation placed in the member's file.
13. If at any time during an External Review, the enrollee submits information to the Plan that is relevant to the Plan's resolution and was not considered in the previous Appeal reviews:
  - a. The Plan shall reconsider the previous resolution based on the additional information.
  - b. Independent Review Organization shall cease the external review process until the reconsideration by the Plan is completed.

- c. The Plan shall notify the enrollee of the Plan’s decision 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; or
  - iii. within fifteen (15) business days after the information is submitted for a reconsideration of a standard Pre-service or Post-service Appeal.
- d. If the reconsideration decision is adverse to the enrollee, the enrollee may request that the Independent Review Organization resume the external review process.

**VI. References/Citations**

IN Code: IC 27-8-28  
 PPACA Legislation  
 NCQA Standards UM8A

**VII. Forms/Appendices**

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**VIII. Responsibility**

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**IX. Approval Body/Approval Signatures**

(Signatures required of Policy owner, Department Director, Business Line Director, Compliance Director, and final signature of CFO/COO or CEO)

Trina Gibson Director, Customer Solutions Center Indiana University Health Plans	Date	
Karlin Dunlop Executive Director of Compliance and Member Services Indiana University Health Plans		Date
Constance Brown COO/CFO Indiana University Health Plans		Date

