

PHYSICIANS HEALTH PLAN OF NORTHERN INDIANA, INC.

**POLICY & PROCEDURE**

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**Policy Title:** Grievance Policy and Procedure

**Origination Date:** July 31, 2013

**Policy No.:** CUS0451

**Effective Date:** July 31, 2013

**Section:** Customer Service- Grievance

**Revision Date:** 4/18/2014

**Approved By:** Gail Doran, COO and Quality Improvement Committee

**Approved Date:** 4/18/2014

**Review Date:** 4/18/14, 4/14/15

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**Purpose**

To ensure all grievance complaints are handled in a consistent manner in accordance with all appropriate state, federal and URAC standards.

**Policy**

It is the Policy of Physicians Health Plan of Northern Indiana, Inc. (PHP), that the Grievance process shall be in compliance with Department of Labor and State of Indiana guidelines, timeframes and regulations, and also with applicable URAC complaint standards.

**DEFINITIONS**

**Grievance:** Grievances are an administrative review required before an appeal by the state of Indiana.

- a) Indiana Code IC 27-8-28-6 defines a grievance as any dissatisfaction expressed by or on behalf of a covered individual regarding:
1. A determination that a service or proposed service is not appropriate or medically necessary
  2. A determination that a service or proposed service is experimental or investigational
  3. The availability of a participating provider
  4. The handling or payment of claims for health care services
  5. Matters pertaining to the contractual relationship between:
    - a. A covered individual and an insurer; or
    - b. A group policyholder and an insurer; or
    - c. An insured's decision to rescind an accident and sickness insurance policy and for which the covered individual has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.
- b) Per Indiana Code 27-8-28-16 (a) (1) and Indiana Code 27-13-10-7(a) (1), for each grievance received, PHP will send an acknowledgement letter of the grievance in writing, to the member or their designated representative within (3) business days.
- c) Pre-service (lack of certification) grievance will be resolved in 15 days, and post-service grievances will be resolved in 20 business days.
- d) **Designated Representative**  
An individual the member has appointed to assist or represent them with a grievance. This person may include, but not be limited to, physicians, other providers, attorneys, friends, or family members. They must identify their designated representative to us in writing, though, in order to prevent the disclosure of your medical information to unauthorized persons.

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e) Filing Time Limit

All requests for consideration of an adverse benefit determination must be received within 180 days of the date of the adverse benefit determination.

**TOLL-FREE ACCESS (IC-27-13-10-5)**

PHP provides a toll-free telephone number (1-800-982-6257, Extension 361) for local or long-distance callers through which members may obtain information on their rights. PHP utilizes the AT&T Language Line which provides access to translation services staff who speak a number of different languages and who are available to assist the CRC in speaking with members of non-English-speaking origin.

**Procedure(s)**

Grievances may be submitted to PHP verbally or in writing, either by the member or by a person the member has appointed in writing as his or her designated representative, including a health care provider. A grievance that is initiated by the Indiana Department of Insurance (IDOI) will follow the grievance process in accordance with IDOI requirements. PHP shall review this Policy & Procedure for any appropriate revisions on an annual basis.

This Policy & Procedure does not govern any issue governed or covered, in whole or in part, by the Indiana Medical Malpractice Act. All such claims must be brought in accordance with applicable Indiana law.

1. Reviewers – All grievance considerations will be conducted by a review panel consisting of the following PHP panel:
  - Medical Management Manager
  - Contract Production and Sales Coordinator
  - Director of Client Services
  - Benefits Specialist
  - Corporate Compliance Officer
2. As part of the grievance process, PHP's review panel shall:
  - Provide the patient, provider, or facility rendering service the opportunity to submit written comments, document records, and other information relating to the case.
  - Take into account all documentation, comments, records and all other information related to the case that was submitted with the grievance by patients, provider, and/or facilities rendering service(s), without regard to whether such information was submitted or considered in the initial consideration of the case/request for certification
  - Review that all PHP policy, procedures and protocols were followed in the original review of the benefit determination.
3. All grievances will be resolved as soon possible or within 20 business days after the grievance is filed (whichever comes first). If the grievance cannot be resolved within the timeframe specified, PHP will notify the member or their designated representative, in writing, of the delay and the reason for the delay and request and extension. If an extension is necessary, the grievance must be resolved and a written decision issued within 10 business days.
4. The CRC will provide written notification of the determination of the grievance review within 5 days of the decision. The notice will include the rationale for the determination process, the policies or procedures used in the decision and the process for seeking further review. Grievance notification letters will also include the contact information for PHP's CRC.

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5. All grievances, including all correspondence, decisions and reviewed records will be documented and maintained in the case file by the CRC and tracked in the grievance/appeal log as required by IC-27-13-10-5.
6. All grievances will be tracked on a quarterly basis by the Customer Relations Coordinator, and analyzed for trending purposes by the COO and Medical Director. The analysis for trending purposes will be provided to the Quality Improvement Committee on a quarterly basis.

**References:**

Grievance process guidelines & work charts  
Grievance acknowledgement letter(s)  
Grievance decision letters

**Standard / Regulation #:**

IC27-13-10  
DOL TR2013-01  
26 CFR Parts 54 and 602  
2560.503-1(b) & (c)

**Accreditation Standard:**

**Reviewed By** Chief Operations Officer, Manager of Medical Management, Director of Client Services, Manager of Client Services, Quality Lead, & Quality Improvement Committee.

**Revision Dates History:**

4-18-2014

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**Policy Title:** Appeal Policy and Procedure

**Origination Date:** Sep 1, 1997

**Policy No.:** CUS0300

**Effective Date:** March 13, 2013

**Section:** Customer Service - Appeals

**Approved By:** Gail Doran, COO and  
Quality Improvement Committee

**Revision Date:** 8/12/13, 4/28/14

**Approved Date:** April 28, 2014

**Review Date:** 8/12/13, 4/14/15

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**Purpose**

To ensure all appeals and Independent Review Organization (IRO) requests are handled in a consistent manner in accordance with all appropriate state and federal laws and in accordance with URAC standards.

**Policy**

It is the Policy of Physicians Health Plan of Northern Indiana, Inc. (PHP), that the Appeal process shall be in compliance with Department of Labor and State of Indiana guidelines, timeframes and regulations, and also with applicable URAC standards. PHP will maintain a formal process to consider appeals for medical necessity decisions that resulted in a non-authorization of services including the availability of a standard appeal for non-urgent cases and expedited appeal for cases involving urgent care. Urgent and standard appeals are available upon request, to any patient, provider, or facility rendering service.

**DEFINITIONS**

**Appeal**

- a) A verbal or written request to PHP by a consumer, ordering physician, or prescriber to change its decision regarding an adverse benefit determination, or a request for appeal as outlined in the Indigo Member Certificate of Coverage regarding eligibility. Expedited appeals will be completed within 72 hours. Appeals will be resolved within 15 calendar days.
- b) **Designated Representative**  
An individual the member has appointed to assist or represent them with an appeal, expedited appeal, or external appeal. This person may include, but not be limited to, physicians, other providers, attorneys, friends, or family members. They must identify their designated representative to us in writing, though, in order to prevent the disclosure of your medical information to unauthorized persons.
- c) **External Appeal** (Sometimes identified as an Independent Review Organization)  
An appeal process in which an IRO reviews certain appeal and expedited appeal decisions PHP made and determines whether to uphold or reverse them.
- d) **Filing Time Limit**  
All requests for reconsideration of an adverse benefit determination must be received within the following time frames once the adverse benefit determination has been made.

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<b>Level Requested</b>	<b>Group</b>	<b>Indigo</b>
Urgent Appeal	72 hours	72 hours
Appeal	180 days	180 day
IRO(External appeal)	120 days	120 days

e) Final Internal Adverse Benefit Determination

The upholding of an adverse benefit determination at the conclusion of the internal appeals process or an adverse benefit determination internal appeals process has been deemed exhausted.

f) Independent Review Organization (or IRO)

An organization licensed by the Indiana Department of Insurance to conduct external appeals.

g) Urgent Care Appeals

An expedited appeal process allows for an accelerated review by PHP of a medical necessity denial decision. It is available only when a reasonable lay person believes that life, health, or ability to reach and maintain maximum function would be seriously jeopardized due to a sickness, disease, condition, injury, or disability, or in the opinion of the member's physician would subject the member to severe pain that cannot be adequately managed. If these conditions are met, a decision will be rendered as soon as possible, but no later than 72 hours from the time of the service request.

**TOLL-FREE ACCESS (IC-27-13-10-5)**

PHP provides a toll-free telephone number (1-800-982-6257, Extension 361) for local or long-distance callers through which members may obtain information on their rights. PHP utilizes the AT&T Language Line which provides access to translation services staff who speak a number of different languages and who are available to assist the CRC in speaking with members of non-English-speaking origin.

**Procedure(s)**

Appeals may be submitted to PHP verbally or in writing, either by the member or by a person the member has appointed in writing as his or her designated representative, including a health care provider. An appeal that is initiated by the Indiana Department of Insurance (IDOI) will follow the appeal process in accordance with IDOI requirements. PHP shall review this Policy & Procedure for any appropriate revisions on an annual basis.

This Policy & Procedure does not govern any issue governed or covered, in whole or in part, by the Indiana Medical Malpractice Act. All such claims must be brought in accordance with applicable Indiana law.

1. When a Lack of Certification notification letter is sent to the requesting providers and to the request originators including facilities rendering service(s) and patients, it will contain a statement allowing 180 days for a member to submit an appeal for reconsideration of the following:
  - o Non-certification determination.
  - o A statement sent to the patient, provider, and/or facility rendering service(s) that they may submit written comments, documents, records, and other information relating to the case.
  - o Summation of the member's appeal rights.
2. When an appeal is received in response to a non-certification (pre-service) determination, the Customer Relations Coordinator (CRC) and the Medical Director will, within 1 calendar day, forward the appeal to Clinix. Within 3 business days an acknowledgment letter will be sent to the member and/or the member's designated representative. See Process Guideline Appeal Hearing Workflow.

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3. Independent Medical Reviewer – All appeal considerations will be conducted by Clinix, a URAC accredited company, who shall assign appeal considerations to health professionals who:
  - Are clinical peers;
  - Hold an unrestricted, active license or certification to practice medicine or a health profession in a state or territory of the United States;
  - 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.
  - Are Board-certified 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 (for Doctors of Osteopathic Medicine);
  - Are in the same profession and in similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate;
  - Are neither the individual who made the original Lack of Certification decision, nor a subordinate of such an individual; and
  - Who will follow the guidelines, as per this Policy.
  
4. As part of the Appeals process, PHP and the independent medical reviewer considering the Appeal shall:
  - Provide the patient, provider, or facility rendering service the opportunity to submit written comments, documents records, and other information relating to the case
  - Take into account all documents, comments, records, and all other information related to the case that was submitted with the appeal by patients, providers, and/or facilities rendering service(s), without regard to whether such information was submitted or considered in the initial consideration of the case/request for certification.
  
5. For each appeal case they accept, the appeal reviewer will attest through written documentation that they have a scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review, and current, relevant experience and/or knowledge to render a determination for the case under review.
  
6. If the person making the appeal is a provider of care or a physician, the Independent Medical Reviewer may choose to speak directly with that person or his/her representative.
  
7. In the case of a standard appeal, the Independent Medical Reviewer will provide a decision within 14 calendar days of receipt of the request for appeal including written notification of the appeal decision to the patient and attending physician or other ordering provider or facility rendering service.
  
8. In the case of the expedited appeal, the Chief Operating Officer ensures the Medical Director communicates the Independent Medical Reviewers decision to the originator of the appeal within 72 hours (3 calendar days) from the initiation of the Appeal to PHP. Written confirmation of the expedited appeal determination will be provided within three calendar days to the patient, and his or her designated representative, if applicable and the attending physician or other ordering provider or facility rendering service. Information may be conveyed orally and followed up with a written confirmation.
  
9. A medical necessity appeal must be conducted and resolved within 15 calendar days. The CRC will provide a written appeal response within 5 business days of resolution which will include the following:
  - The principal reason(s) for the determination to uphold the non-certification;

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- A statement that the clinical rationale used in making the appeal decision will be provided in writing, upon request; and
  - Information about additional appeal mechanisms, if available through the Plan sponsor for ASO.
10. **External Review (IRO):** In the event of continued denial the member may file a written request for an IRO (External Appeal) with PHP within 120 days after they receive the notice of the Appeal or Expedited Appeal decision. In accordance with Indiana law, IRO's will be assigned on a sequential basis through a list of certified review organizations maintained by the Indiana Department of Insurance. The assignment of IROs will be made by PHP from the approved list on the IDOI website. PHP will access and rely on appropriate clinical expertise in rendering independent review determinations.
11. **Standard IRO:** Upon receipt of the IRO (External appeal), an acknowledgement letter will be sent to the member and/or member's designated representative within 3 business days. The person or organization appealing will be provided with written notification of the final determination and the notice will include the rationale for the final determination and the process for seeking further review, if available. The IRO must render a decision within 15 business days after appeal is filed. Notification of the decision will be sent to the member and/or the member's designated representative by the IRO and/or PHP within 72 hours of the decision.

**Urgent IRO:** In determinations for cases involving urgent care, the IRO will render the determination with 72 hours from the date the consumer initiated the independent review. The IRO will notify the member within 24 hours of the decision for urgent or expedited appeals.

The IRO reviewer may not have been involved in the original determination under appeal. PHP is responsible for any additional costs of the IRO (External Appeal) for fully-insured and Indigo Individual members. The member is required to cooperate with the IRO by providing or authorizing the release of any necessary medical information that PHP hasn't already provided. At all times during the External Appeal process, the member is permitted to submit any relevant information to the IRO. The IRO will not have any direct financial interest in PHP or the outcome of the independent review. The determination of the IRO is binding on PHP.

12. All Appeals will be recorded in the case file by the CRC.
13. The Appeals record is contained in the applicable case file which contains, at minimum:
- The name of the patient, provider, and/or facility rendering service(s);
  - Copies of all correspondence from the patient, provider, and/or facility rendering service(s) and correspondence from the contracted Independent Medical Review service to the patient, provider, and/or facility rendering service(s) regarding the appeal;
  - Dates of all appeal reviews, documentation of actions taken, and final resolution or determinations; and
  - Minutes or transcripts of appeal proceeding.
  - Name and credentials of the clinical peer that meets the qualifications in standard (P-HUM 33).
14. All Appeals will be tracked on a quarterly basis by the Customer Relations Coordinator, and analyzed for trending purposes by the COO, and Medical Director. The analysis of Appeals for trending purposes will be provided to the Quality Improvement Committee on a quarterly basis.

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PHP utilizes Clinix, a URAC Accredited Company, to have their Independent Medical Reviewers review all appeal cases. Clinix will make the medical determination and PHP is bound by their decision as set forth in the contract (P-HUM 34 c). Please note this statement only applies to appeals, all IRO's (External Appeals) will be assigned on a sequential basis through a list of certified review organizations maintained by the Indiana Department of Insurance.

**References:**

**Standard / Regulation #:**

IC27-13-10  
45 CFR § 147.128  
45 CFR § 147.136  
29 CFR § 2560.503-1  
29 CFR § 147.128  
DOL TR 2013-01

**Accreditation Standard:** URAC: HUM 32, 33,34,35,36,38

**Reviewed By** Chief Operations Officer, Manager of Medical Management, Director of Client Services, Manager of Client Services, Non-Clinical Quality Supervisor, and Quality Improvement Committee.