

SIHO CORPORATE POLICY WITH PROCEDURES

CS: 14:03 R2

APPEALS PROCEDURES (Replaces ERS 11:34 R3)

Created By: Cathy Dykes

EFFECTIVE DATE: 11/1/2011

Approved By: Dawn Coomer / Doug Fauth

REVISION DATE: 08/24/15

Revised By: Gretchen DeBord

NEXT REVIEW DATE: 08/24/16

1.0 SCOPE

TPA and Fully Insured Appeal requests. The administration and review is the responsibility of Appeals Coordinator. This policy complies with the requirements of the Patient Protection and Affordable Care Act (PPACA), URAC accreditation standards; and local, state(referenced at end of document) and federal statutes.

Any adverse benefits decision may be appealed. This is defined by PPACA as “denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit.” These adverse benefit decisions may be based on eligibility, benefit coverage, limitations on otherwise covered benefits (such as preexisting condition exclusions, source-of-injury exclusions, and network exclusions), and a determination that a benefit is experimental or not medically necessary.

Appeals procedures are available, upon request, to any patient, provider or facility rendering services by contacting Member Services at the number listed on the Member ID card. An appeal may be filed by the consumer, provider, or facility rendering service either verbally or in writing as required by local, state, federal or URAC accrediting standards. Fully Insured participants will have one hundred eighty (180) days from the receipt of SIHO’s original decision to appeal the denial as consistent with PPACA requirements. TPA participants may appeal later than 180 days, if allowed in the Summary Plan Description.

In addition to appeals submitted by the consumer, provider, or facility rendering service, any SIHO employee who has been unable to resolve the issue as a complaint may take the appeal information.

2.0 PURPOSE

To provide a consistent and timely process for the documentation, investigation, evaluation and resolution of all appeals.

3.0 POLICY

All appeals will be thoroughly investigated, evaluated and resolved in a timely manner and in compliance with applicable local, state, federal or URAC accreditation statutes. Documentation will be entered into SIHO’s internal system.

4.0 STANDARD APPEAL PROCEDURES

- 4.1 All appeal requests will be forwarded to the Appeals Coordinator to be handled through the appeal procedures.
 - 4.1.1 When the appeal is initially received, the Appeals Coordinator will document the appeal in the appropriate electronic Appeals Log (IU or FI/TPA) found on the Appeals network drive. Throughout the process, the Appeals Coordinator will continue to update this log as information is received specific to the appeal.
 - 4.1.2 The Appeals Coordinator will create an electronic file folder for each Appeal received. The documentation, including correspondence, received with the initial appeal will be scanned and saved on the Appeals network drive. All correspondence (both sent and received), review documentation, and final determination related to the appeal will be saved in the electronic folder. This electronic folder will be retained on the Appeals network drive for a minimum period of six (6) years from the date of the last benefit determination.
 - 4.1.3 For all appeals that are received from a current group, and within the timely filing limits the Appeals Coordinator will research the system to gather the following information: who submitted the appeal, what is being appealed, claim information (DOS, denial reasons, process dates), CUTs/Events (benefits quoted/claims review, etc), and SPD benefits/Certificate of Coverage.
- 4.2 For all requests (verbal or written), the Appeals Coordinator will enter a CUT log in the OAO system or an Event log in the HSP system documenting the appeal. The CUT/Event will include what is being appealed, give claims and/or authorization information when appropriate, and indicate that the Appeals Coordinator will research and submit for appropriate review.
- 4.3 For all written requests (both member and provider), an acknowledgement notice will be sent to the member within three (3) business days of receipt of the appeal request.
- 4.4 The Appeals Coordinator will begin investigating the issue and gather the data needed to review the circumstances surrounding the appeal, including, but not limited to; call history, claims history, referral history, medical records, and SPD benefits or Certificate of Coverage.
- 4.5 The Appeals Coordinator is authorized to overturn any initial determination that involves an error made by SIHO or a SIHO provider and does not involve medical necessity, appropriateness determinations, or benefit issues/limitations, up to \$1,500.
- 4.6 The Appeals Coordinator will review common appeals to determine if a previously researched and documented determination exists for the type of appeal submitted. If a Standard Appeal Determination Practices is documented, the Appeals Coordinator will examine all facts and circumstances to determine if there is any basis to distinguish the present case from the prior ones, and if not the Appeals Coordinator is deemed the Appeals Committee for the case and will send the appropriate notice.. The following are responses to common appeals:

- 4.6.1 If the appeal was not received within the timely filing limits of the plan, a letter will be sent out stating that the appeal could not be reviewed; SPD pages showing the filing limit will be included.
- 4.6.2 If the appellant is asking for a review of Air Ambulance charges, and the Appeals Coordinator determined that the claim was paid according to the member SPD, enter a CUT or Event. Notify the appellant via letter that the claim was paid appropriately.
- 4.6.3 For denial of professional fees for lab (HPV test, etc) that the Appeals Coordinator determined was appropriate, enter a CUT or Event and send a letter to the appellant to advise that the charge is not payable as billed.
- 4.6.4 If the appeal is for a group that has terminated their contract with SIHO, and we are NOT doing run out, send a letter to the appellant stating that we are no longer administering the benefits for that plan. If possible include the new carrier information. If the claim would have been received during the run out time, but was received after the run out ended, a letter should be sent to the appellant stating this.
- 4.7 For Appeals that are non-medical in determination, an Appeals Committee consisting of the Appeals Coordinator, Representative from Employee Services Department, Manager appointed representative from Member Services Department, Manager appointed representative from Quality Assurance Department, and Manager appointed representative from Claims Department, (or so many of them as are available) will meet on a weekly basis to review and make appropriate determination for how the appeal should be resolved.
 - 4.7.1 The Appeals Committee will review the appeal documents and render a determination. The Appeals Committee has no authority to overturn benefit exclusion or limitations. The Appeals Committee can make recommendations for TPA account exception or benefit changes if appropriate. These recommendations will be communicated to Account Management or the Fully Insured Department via the Appeals Coordinator.
 - 4.7.2 If the appellant is asking the claim to be paid “in-network” or with a discount and the provider has stated they are out of network, the Appeals Coordinator will determine how the claim was paid. If it is determined the claim was paid in-network due to emergency per their SPD, enter a CUT or Event stating how the claim was paid and send a letter to the provider stating how the claim was paid and why. Also, state that as a non-contracted provider they are not required to accept any reduction in billed charges and may balance bill the patient.
 - 4.7.3 If the appellant is asking for a review of claims or charges that were denied for a bundling issue through the HBO and Company system, claim check edits, or any other coding guideline, the Appeals Coordinator will create a review packet including claim information along with the appeal. A CUT/Event should be entered and the appeal should be forwarded to Data Analytics for determination (and reporting back to the Appeals Coordinator who will communicate the decision to the appellant).

- 4.7.4 If the appellant is asking for timely filing review, enter a CUT/Event and create a review packet including claim information. Depending on the group (Fully Insured or Self-Funded), the claim information should be routed to the appropriate department for review. Upon review of the appeal, if the timely filing is waived and the claim will be processed for payment, the CUT/Event should be updated and routed to the appropriate claims processor. If timely filing will not be waived, a letter should be sent to the appellant describing why the timely filing will not be waived, SPD information may be included, and the appellant should be notified they may submit additional information if available.
- 4.7.5 If the appellant is asking for a review of contracted rates or paid amounts and the network is SIHO, enter a CUT/Event and forward the appeal to Provider Relations for review. If the network is a Rental Network enter a CUT/Event and forward to the Rental Network Liaison for review. Once a decision has come back, the Appeals Coordinator will forward the claims for reprocessing or send a letter to the appellant stating the rates are correct.
- 4.7.6 If an appellant is disputing the discount taken on a claim, enter a CUT/Event. If the network is SIHO, forward to Provider Relations to review contract language. If the network is a Rental Network, forward to the Rental Network Liaison to have reviewed by network.
- 4.7.7 If the appellant is disputing the discount because the claim was not paid timely, and the group is Self-Funded, the Appeals Coordinator will research. The research will include: when the claim was received, if medical records were requested/received, if the group was funding claims in a timely manner, and how long it took to process the claim once it was determined to be a clean claim. Once this information is gathered it will be presented to the Appeals Committee to determine if they agree that the discount should be reimbursed to the provider. If the discount should be paid, and slow payment was the result of untimely claims funding by the employer, the discount should be processed for payment to the provider and that amount should be billed to the Employer Group.
- 4.7.8 For all other non-medical appeals, the Appeals Coordinator will gather all previous information (including complaints or grievances), research with other internal departments as necessary, and present the information to the Appeals Committee to determine the resolution of the appeal. Once the decision has been made, the appropriate department will notify the appellant of the status.
- 4.8 For Appeals that are medical in determination or need the review of a physician review, the Appeals Coordinator shall appoint a panel of one or more qualified individuals to determine the matter. The appeals panel must attest for each case:
 - (a) have knowledge of the medical condition, procedure or treatment at issue;
 - (b) have a scope of licensure or certification that typically manages the condition, procedure, treatment or issue under review;
 - (c) were not involved in the matter giving rise to the appeal or in the initial investigation of the grievance;
 - (d) do not have a direct business relationship with the covered individual or the health care

provider who previously recommended the health care procedure, treatment or service giving rise to the grievance ; (e) were not the physician generating the original decision; and (f) is not a physician that reports to the physician making the original decision.

- 4.8.1 If the Associate Medical Director is qualified in accordance with the prior sentence to make the determination, then he/she will do so. Upon documenting the appeal determination, the reviewing party will sign an attestation indicating that the requirements in 4.8 above have been met.
- 4.8.2 If the Associate Medical Director is not so qualified, then the appeal shall be determined by the Medical Director (or a different Associate Medical Director) if he/she is so qualified. Upon documenting the appeal determination, the reviewing party will sign an attestation indicating that the requirements in 4.8 above have been met. Note: 4.8.1 may be bypassed if the Medical Director is qualified and makes a determination without first involving an Associate Medical Director.
- 4.8.3 If there are no internal persons so qualified, or if the matter is of such complication or specialization that the Medical Director or Appeals Committee deems it appropriate to engage outside medical specialists, then the Appeals Coordinator will send all relevant information to a third party who is qualified to determine the appeal. Upon documenting the appeal determination, the reviewing party will sign an attestation indicating that the requirements in 4.8 above have been met.
- 4.8.4 If the appellant submitted medical records for review of a denied ER claim, the Appeals Coordinator will create a packet (screen prints of claims that were denied, copy of SPD language regarding coverage for ER services, and Mercy Rule language if applicable), enter a CUT/Event, and route to the Case Manager to submit to Medical Director.
- 4.8.5 If the claim was reversed per the review described in this section, enter a CUT/Event and route to the appropriate department for the claim to be reprocessed or authorization to be updated. If the decision was made to uphold the denial, enter a CUT/Event and send a letter to the appellant to notify them the claim has been denied and why the decision was made. Copies of the SPD language showing the reason for the decision should be included.
- 4.9 For any other type of appeal, not listed above, after all research has been completed, the Appeals Coordinator will do the following: create a summary sheet and present the appeal during the meeting for review. If the claim was reversed per the committee's decision, enter a CUT/Event and route to the appropriate department for the claim to be reprocessed or authorization to be updated. If the committee voted to uphold the denial, enter a CUT/Event and send a letter to the appellant to notify them the claim has been denied and why the decision was made. Copies of the SPD language showing the reason for the decision should be included.
- 4.10 The resolution of all appeals should be documented and forwarded to the appropriate department if further action is needed. All final appeal documentation

is scanned into the ISynergy system for future reference. Any improvements to current processes should be discussed with the appropriate departments and corrective action plans implemented.

- 4.11 All appeals will be entered into the log record upon the resolution of the appeal. This log will include information regarding when the appeal was received, who submitted the appeal (provider or member), the name of the member, their identification number, reason for appeal code, discipline code (cardiology, orthopedics, oncology, etc), decision code, outcome of appeal, and date response sent. Appeal codes, discipline codes, and decision codes can be found on Attachment 1 of this document.
- 4.12 Per local, state, federal and accreditation statutes, notification of the resolution of the appeal will be sent to the appellant within thirty (30) calendar days of the receipt of the appeal request. This notice will include the appellant's right to request an External Review per applicable governmental guidelines for non-grandfathered plans.
- 4.13 Appeal documentation will be trended by the Appeals Coordinator and reported to the Quality Management Committee as requested.
- 4.14 The Appeals Coordinator will begin compiling all information on appeals for Fully Insured claims from the previous year on January 15th. This log will be sent to the Vice President and Controller of Finance Department and the Vice President and Director of Fully Insured no later than February 1st. At that time, the Financial Operations Director and Assistant Controller will also receive a copy of this log. The Finance Department will then submit appeals to the Indiana Department of Insurance (IDOI) by March 1st.

5.0 CLAIMANTS RIGHTS ON APPEALS

- 5.1 The appealing party will have the opportunity to submit written comments, documents, or other information relating to the issue.
- 5.2 Upon request and free of charge, the claimant will be provided with reasonable access to and copies of, all documents, records and other information relevant to the appeal.
- 5.3 The appeal review will take into account all comments, documents, records and other information the claimant submits, whether or not presented or considered in the initial determination.
- 5.4 No deference will be afforded to the initial determination.
- 5.5 The review will be conducted by a person different from the person who made the initial determination and who is not the original decision-makers subordinate.
- 5.6 If the decision is made on the grounds of a medical judgment, SIHO will consult with a health care professional with appropriate training and experience. The health care professional will not be the individual who was consulted during the initial determination or that person's subordinate.
- 5.7 SIHO will provide the claimant with the name of any medical or vocational expert who advised SIHO with regard to the appeal.

6.0 DRUG UTILIZATION MANAGEMENT APPEALS

6.1 For Appeals that are deemed as drug utilization appeals, the Appeals Coordinator shall appoint a panel of one or more qualified individuals to determine the matter. The panel must include one or more individuals who (a) have knowledge of the medical condition, procedure or treatment at issue; (b) hold an active, unrestricted license or certification to practice pharmacy in a state or territory of the United States (c) were not involved in the matter giving rise to the appeal or in the initial investigation of the grievance, (nor a subordinate of such an individual); (d) Unless expressly allowed by state or federal law or regulation, are located in a state or territory of the United States when conducting appeal review; (e) may not conduct drug utilization management appeal review if, prohibited by state appeal laws or the requesting party requests specifically for a clinical peer (f) do not have a direct business relationship with the covered individual or the health care provider who previously recommended the health care procedure, treatment or service giving rise to the grievance;

- 6.1.1 If the Associate Medical Director is qualified in accordance with the prior sentence to make the determination, then s/he will do so.
- 6.1.2 If there are no internal persons so qualified, then the Appeals Coordinator will send all relevant information to a third party who is qualified to determine the appeal.
- 6.1.3 If the claim was reversed per the review described in this section, enter a CUT/Event and route to the appropriate department for the claim to be reprocessed or authorization to be updated. If the decision was made to uphold the denial, enter a CUT/Event and a letter sent to the appellant to notify them the claim has been denied and why the decision was made. Copies of the SPD language showing the reason for the decision should be included.

7.0 EXPEDITED APPEALS

- 7.1 The appellant may request an expedited appeal either verbally or in writing, or SIHO may independently determine that the process should be expedited due to the medical necessity of the appeal. The expedited process is considered a stand-alone procedure and is in lieu of the standard appeal procedure outlined in section 4.0 of this policy.
- 7.2 The process to resolve an expedited appeal will be the same as a non-expedited except for the accelerated time frames described in this section.
- 7.3 Resolution of an expedited appeal will be made as expeditiously as the appellant's health warrants but will occur no later than 72 hours after the filing of the appeal.
- 7.4 The appellant or their designated representative will be verbally notified within the 72 hours of the expedited appeal determination. Within one (1) business day after the verbal notification, a notice will be sent via mail to the appellant regarding the expedited appeal determination.

8.0 NOTIFICATION OF RESOLUTION OF APPEAL

- 8.1 **Urgent Care Claims:** In the case of an appeal involving an urgent care issue, SIHO will notify the claimant of its decision within 72 hours after it received the request for review.
- 8.2 **Pre-Service Claims:** In the case of a Pre-Service issue not involving urgent care, SIHO will notify the appealing party of its decision within 15 days after it receives the request for review.
- 8.3 **Other Claims:** In the case of all other issues, SIHO will notify the appealing party within 20 business days after it receives the written request for review.
- 8.4 The Appeals Coordinator will access the Appeals Drive when replying back to the appellant. The template letters are housed in the appeals drive separated by the year depending on the date of service.

9.0 NOTICE OF DECISION ON INITIAL APPEAL

- 9.1 If an initial appeal is denied, SIHO will notify the claimant, in writing or electronically. The notice will contain the following information:
 - the specific reason (s) for denial;
 - a reference to the specific SPD provision (s) on which the denial is based;
 - a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse determination;
 - An explanation of any scientific or clinical judgment on which the denial is based.
 - a statement that the claimant is entitled to receive, upon request and without charge, reasonable access to and copies of all documents, records or other information relevant to the appeal
 - a statement describing the voluntary appeal procedures via the external review offered by the Health Plan and the claimant's right to obtain information about the procedures
 - The name, address and telephone of the Appeals Coordinator whom the claimant may contact for more information.

10.0 EXTERNAL REVIEW OF APPEALS PROCESS

- 10.1 If the appellant is dissatisfied with the Appeal Committee's resolution, and the denial is based upon medical necessity, appropriateness, health care setting, level of care, experimental or investigational, effectiveness of a covered benefit or rescission of coverage, he or she may file a written request to initiate an External Review of Grievance/Appeal. This request must be filed no later than four months after the appellant is notified of the resolution of the prior appeal for TPA customers and not later than 120 days after the appellant is notified of the resolution of the prior appeal for Fully Insured business.
- 10.2 An appellant may not file more than one (1) External Appeal request on the same

- appeal.
- 10.3 Upon receipt of the request for External Appeal review, the Appeals Coordinator will enter a cut/event via the processing system. The Appeals Coordinator will select an independent review organization that is certified to perform external reviews under PPACA and URAC regulations, has not been involved in the original determination under appeal, and is listed as approved by the Indiana Department of Insurance at http://www.in.gov/idoi/files/IRO_Rotation_List_website_11-20-13-a-1.doc.doc.
 - 10.4 The appeals should be sent to these organizations in sequential order from the rotation list indicated above. No review organization shall be used again until all other review organizations have been used once. In order to create a consistent process, self-funded appeals will follow the same process as the fully-insured appeals. The pre-determined list of organizations to send external appeals to for fully-insured and self-funded groups is titled "External Reviewer" and is saved in the Appeals Drive in the External Review folder.
 - 10.5 The external review organization and the medical review professional conducting the external review may not have a material professional, familial, or financial, or other affiliation with SIHO; any officer, director, or management employee of SIHO; the physician or the physician's medical group that is proposing the service; the facility at which the service would be provided; or the development or manufacture of the principal drug, device, procedure, or other therapy that is proposed by the treating physician.
 - 10.6 An appellant who files an appeal under this final alternative is not subject to retaliation for exercising their right to an appeal by an external review organization. An appellant may be permitted to utilize the assistance of other individuals, including physicians, attorneys, friends, and family members throughout the external review process. An appellant shall be permitted to submit additional information relating to the proposed service throughout the review process and may cooperate with the external review organization by providing any requested medical information or authorizing the release of necessary medical information.
 - 10.7 SIHO shall cooperate with the external review organization by promptly providing any information requested by the external review organization.
 - 10.8 The external review organization shall make a determination to uphold or reverse SIHO's appeal resolution based on information gathered from the appellant, SIHO, the treating physician, or any additional information that the external review organization considers necessary and appropriate. For standard appeals, the determination shall be made within 15 business days from the filing date of the request for external review. For expedited appeals, the determination shall be made within 24 hours after the external review request is filed. **The result of the determination is binding on SIHO.**
 - 10.9 When making the determination of the resolution of the appeal, the external review organization shall apply the standards of decision making that are based on objective clinical evidence and the terms of the appellant's benefit contract.
 - 10.10 If at any time during the external review process the appellant submits information to SIHO that is relevant to SIHO's previous appeal resolution and

was not considered by SIHO during the appeals phase, SIHO shall reconsider the previous resolution under the appeals hearing process. The external review organization shall cease the external review process until the reconsideration by SIHO is completed.

- 10.11 If the reconsideration determination made by SIHO is adverse to the appellant, the Appellant may request that the external review organization resume the external review.

11.0 DEFINITIONS

- 11.1 An appeal is an oral or written request from a member or provider to change a previous decision made by SIHO that was unresolved to the member or provider's satisfaction at the first appeal.
- 11.2 An Expedited appeal is an appeal that is completed within 72 hours of the request and followed by a written confirmation of the notification.
- 11.3 An External appeal is an appeal that is sent to an independent reviewer after all internal appeal mechanisms have been exhausted, for clinical determinations relating to the necessity or appropriateness of medical services.
- 11.4A Drug Utilization Management Appeal is an appeal based on a process of appraising and reconsidering the usage of drugs to determine the effectiveness of drug treatment

12.0 REFERENCES

- 12.1 IN Code: IC 27-8-28 (Internal Appeals) and IC 27-8-29 (External Appeals)
- 12.2 URAC HUM Standards Version 7.0
- 12.3 PPACA Legislation

ATTACHMENT 1

REASON FOR APPEAL

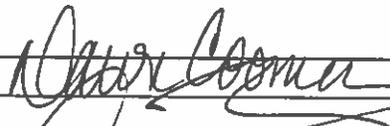
400	Authorization Denied	409	Benefit issue
401	Retro referral	410	Eligibility issue
402	Wrong information given by MS	411	Wrong info given by MM
403	Timely Filing Limit	412	HBOC issue
404	Medical Necessity	413	Emergency Medical Condition
405	Wants claim paid at in-network benefit	414	Claim denied as duplicate
406	Preexisting Condition Issue	415	Pricing Issue
407	Asking us to waive precert penalty	416	Member/Provider report MM call but no log to refer to
408	Other		

DISCIPLINE CODES

101	Allergy	120	Labs or Radiology
102	Ambulance	121	Medicaid/Medicare
103	Anesthesiologist	122	Neurology
104	Assistant Surgeon	123	OB/GYN
105	Bariatric Surgery	124	Optometry
106	Cardiology	125	Orthopedic
107	Chemotherapy/Radiation	126	Pathology
108	Chiropractic	127	Pediatrics
109	Dental	128	Physical/Occupational Therapy
110	Dermatology	129	Plastic Surgery
111	DME	130	Podiatry
112	Emergency Room	131	Preventative
113	ENT	132	Psychiatry
114	Family Practice	133	Pulmonary
115	General Surgery	134	Rehab
116	GI	135	Rheumatology
117	Hospitalization	136	Urology
118	Infertility	137	VA Hospital
119	Internal Medicine	138	Other

REASON FOR OUTCOME DECISION

800	Claims Processed Appropriately	810	Claim Denied – SIHO Error
801	Claim Denied Inappropriately – SIHO Error	811	Denied – Not Medically Necessary
802	Claim Denied Inappropriately – Not SIHO Error	812	Denied – Benefit Exclusion
804	Authorization Denied Appropriately	813	Reversed – Benefit Exception
805	Authorization Denied – SIHO Error	814	Medical Director Decision
806	Denied Inappropriately – Not SIHO Error	815	Provider Error
807	Reversed – Services Not Available in Network	816	Reversed – Medically Necessary
808	Denied – Services Available in Network	817	Other
809	Timely Filing		

Approved By:  (Dawn Coomer) Date: 8/26/15

Approved By:  (Doug Fauth) Date: 8/26/15

SIHO CORPORATE POLICY WITH PROCEDURES

Page 1 of 2

CS:15 05

INDEPENDENT REVIEW ORGANIZATION SELECTION PROCESS FOR APPEALS

Written By: Dawn Coomer

Revised By:

Approved By: Dawn Coomer and Doug Fauth

EFFECTIVE DATE: 9/1/15

REVISION DATE:

REVIEW DATE: 9/01/16

1.0 **SCOPE:** Grievances & Appeals and Compliance and Controller

2.0 **PURPOSE:**

To document the process in order to comply with the IDOI policy for the selection process for IROs for Appeals.

3.0 **POLICY:**

SIHO's policy is to comply with all IDOI policies. The below procedures outline the process for handling external reviews.

4.0 **PROCEDURES**

4.1 The Appeals Coordinator will follow P & P CS 14 03 for all first level appeals.

4.2 For second level appeals which meet the qualifications for a second level review, the Appeals Coordinator will access the list of approved IROs found at <https://secure.in.gov/idoi/2990.htm>.

4.3 The Appeals Coordinator will choose from the list in sequential order. The Appeals Coordinator will send an email to the next available IRO requesting an external review.

4.3.1 If (a) no response is received within 24 hours, (b) the email is returned as undeliverable, (c) the IRO could not complete the review in the necessary timeframe, (d) the IRO lacks a reviewer in that relevant specialty or area of practice, or (e) the IRO completed the internal review/first level appeal, the Appeals Coordinator will notify IDOI via email at rvaughan@idoi.in.gov that the appeal was not accepted.

4.3.1.1 The subject of the e-mail should be: "IRO Rotation Modification"

4.3.1.2 In the body of the e-mail, the following should also be included:

4.3.1.2.1 The name of the IRO being skipped;

4.3.1.2.2 The explanation for skipping that IRO;

4.3.1.2.3 The name of the substituted IRO; and

4.3.1.2.4 The date that the assignment was made to the substituted IRO.

4.3.2 The Appeals Coordinator will contact the next IRO on the list via email.

4.3.3 The Appeals Coordinator will update the External Review log with the dates and actions taken on the appeal. The Appeals Coordinator should also retain proof/documentation of the IRO's failure to respond or the message returning the original email as undeliverable.

SIHO CORPORATE POLICY WITH PROCEDURES

- 4.4 Once the external review is completed, the IRO will send documentation of its decision. The Appeals Coordinator will follow the normal appeals procedures documented in CS 14 03.
- 4.5 If the Appeals Coordinator sends an internal appeal to one of the listed IROs on the IDOI list, he/she will not skip that organization, if it is sequentially the next one on the list, simply for the fact that the organization was used for an internal appeal. For this situation, the only time an IRO would be skipped is if the same case that was previously sent for internal review is determined to need external review. The Appeals Coordinator should never send an external review to an organization that handled the internal review for the same case.
- 4.5.1 In the event that an IRO must be skipped for this reason, the Appeals Coordinator must send the message described above in 4.3.1.*
- 4.6 The Appeals Coordinator will continue selecting the IROs in sequential order without repeating usage of any one of the organizations until each organization has been contacted for an external review (or was skipped due to the IRO completing the internal review) regardless of whether the IRO actually reviewed an appeal.
- 4.7 At any time, if the Appeals Coordinator must skip an organization for any reason except those listed in 4.3.1 and 4.5 above, he/she must obtain management approval before skipping an organization.
- 4.7.1 Once management approval is been obtained, the Appeals Coordinator will contact the IDOI at rvaughan@idoi.in.gov (as described in section 4.3.1) before skipping the organization. The Appeals Coordinator may then proceed with contacting the next sequential organization without waiting on the IDOI response.

5.0 DEFINITIONS

- 5.1 IDOI: Indiana Department of Insurance
5.2 IRO: Independent Review Organization

Approved By: 	Date: 11-17-15
(Appeals)	
Approved By: 	Date: 11/20/15
(Compliance)	