Internal Grievance Review Procedures:

The following procedures apply for the Health Claim Department's handling of internal grievance reviews:

- Within 5 business days following receipt of either a written or oral grievance, the Claim department gives the "Covered Person" or their legal representative an acknowledgment either orally or in writing of that receipt. The acknowledgment includes the name, address, date of filing, and telephone number of an individual they may contact regarding their grievance.

- The Health Operation handling claims for the state of Indiana selects at least one person to resolve the grievance. That person will have knowledge of the medical condition, and of the procedures or treatment. Handling completion could include a referral to the Life/Health Claim Department.

- A review or an investigation is completed:

1. As soon as possible but not more than 20 business days following receipt of information necessary for completion of the review;

2. If a decision is unable to be made within the 20 business days, notify the "Covered Person" or their legal representative in writing, before the 20 days and explain the reasons for delay;

3. Within an additional 10 business days a decision has to be made and send a written notice of the decision;

4. Resolve an appeal of a grievance decision as expeditiously as possible taking into consideration the clinical urgency of the claim. Resolve the appeal no later than forty-five (45) days following the filing of the appeal. In addition, the "Covered Person" or their legal representative is allowed to:

    - Appear in person; or

    - If unable to appear in person, they may communicate with the individual handling the grievance as indicted above;

- Following completion of the review and a decision, send written notice to the "Covered Person" or their legal representative within 5 business days of the decision. The notice includes:

1. The Health Claim decision and the reasons, policies, and/or procedures used in the decision;

2. Written explanation of the “Covered Person’s” right to an external review of the decision by contacting:

    - The Health Operation indicated on the communication; or

    - The Indiana Department of Insurance, 311 W Washington Street, Suite 300, Indianapolis, Indiana 46204-2787, www.in.gov/IDOI/2526.htm

External Grievance Review Procedures:

“External Grievance” means independent review of a grievance and “Department” is the Indiana department of insurance.

External Grievance procedures allow a “Covered Person” or their legal representative to file a written request with Health Claims for an external review of a claim decision.

The request for an external review may include but is not limited to the following:

- Adverse determinations of appropriateness of treatment; or

- Adverse determinations of medical necessity; or

- Determination that a proposed service is experimental or investigational.

Insurance Code 27-8-28 requires that an insurer establish and maintain an external grievance procedure for the resolution of grievances where the “Covered Person” or their legal representative has requested the completion of an external, independent review of the claim decision. The following applies:

- The request for an External Review is made within forty-five (45) days following the notification to the “Covered Person” or their legal representative of the Health Claims internal claim decision;

- A “Covered Person” or their legal representative may not file more than one (1) external grievance for each separate appeal;

- If an independent reviewer is needed, the Life/Health Claim Department will assign a medical review professional who is board certified in the specialty of the appeal and the following guidelines apply:

1. Decision making is based on objective clinical evidence;

2. Complete a review of the terms of the “Covered Person’s” policy;

3. The independent review organization notifies the Health Operation and the “Covered Person” or their legal representative of the determination;

    - Expedited External Grievance Reviews—notification within twenty-four (24) hours following determination:

    - Standard External Grievance Reviews---notification within seventy-two (72) hours following determination.

- **NOTE:** The review organization and medical professional may not have a professional, familial, financial or other affiliation with any persons who are involved directly in the grievance, such as the insurer, the health care provider or the health care provider's medical group that is proposing the service, the facility where the service was performed or the insured;

- However, the medical review professional may have an affiliation under which the medical review professional provides health care services to covered individuals of the insurer and may have an affiliation that is limited to staff privileges at the health facility, if the affiliation is disclosed to the covered individuals and the insurer before commending the review and neither the covered individual nor the insurer objects.

- A “Covered Person” or their legal representative is not required to pay more than twenty-five dollars ($25) of the costs associated with the services of an independent review organization. Any additional costs are paid by the Health Claim department.

Rights and Duties of the Insured During an External Review:

- Permitted to have the assistance of other individuals including health care providers, attorneys, friends, and family members throughout the process of review;

- Can submit additional information relating to the grievance;

- Must cooperate with the independent review organization by providing any requested medical information or authorizing the release of necessary medical information.

Duties of Health Claim Department During an External Review:

- Health Claims will cooperate with the independent review organization by providing any information requested by the review organization;

- If at any time during the review process additional information is submitted and Health Claims determines to resolve the claim, the independent review organization will be notified and the review process is stopped until reconsideration is completed;

- If Health Claims chooses not to reconsider, the information is forwarded to the independent review organization within two (2) business days of receipt in order that the external review may continue;

- Expedited Review requests-Any reconsideration by Health Claims must be completed and a notification or letter sent to the covered individual within seventy-two hours (72) if the reconsideration is related to an illness or condition seriously jeopardizing the “Covered Persons” life or health;

- Any other reconsiderations, following submittal of additional information, are completed within fifteen days (15)

- If the reconsidered decision is adverse to the “Covered Person”, they or their legal representative may request the independent review organization to resume their review.