Anthem.

Grievances and Appeals for Health Plan Members and Providers- Indiana

Title: Grievance Process Insured Indiana Medical Plan Members	**Effective Date**: 02/01/00
Last Revision Date: 01/31/19	**Last Review Date:** 02/21/2020
Distribution: Indiana G&A Management and Associates; Executive Leadership	**Authorization**: Rebecca Harbottle, Staff VP, Grievances and Appeals

I. Purpose

These Grievance and Appeal Procedures ("Grievance Procedures") describe how Anthem Blue Cross and Blue Shield ("Anthem") will process grievances, appeals and external grievances it receives from insured Indiana medical plan Members or their designated representatives. The Grievance Procedures are designed to comply with applicable statutes and the standards of accrediting entities.

II. Policy Statement

A. Anthem encourages its Members to seek resolution of issues by using the procedures contained herein. These procedures are designed to provide meaningful review to Members or their designated representatives who file grievances, appeals or external grievances. Information from grievance and appeal activity can be used to support quality improvement initiatives. These Grievance Procedures are administered without discrimination on the basis of sex, race, creed, or national origin.

B. Some of Anthem's Members or their designated representatives may have physical or mental limitations that make it difficult for them to exercise their rights under the Grievance Procedures. Persons with such limitations should contact Anthem for assistance. Anthem will provide reasonable accommodation to persons with such limitations, working with the individual Member or designated representative to accommodate the specific disability involved.

III. Reporting And Record Keeping Requirements

A. Annual grievance procedure report: On or before March 1 of each year for its insured HMO and POS products and beginning March 1, 2003 for its insured PPO and Traditional products, Anthem will file grievance procedure reports with the Indiana Department of Insurance (Indiana DOI) for the preceding calendar year. One report will include combined information on grievances and appeals received from insured HMO and POS Members. A second report will include combined information on grievances and appeals received from insured PPO and Traditional Members. The special form that will be used for this filing is attached as Attachment A. The reports will be submitted electronically.

B. Grievance register: Anthem will maintain written records that document certain information about all grievances received from Members during a calendar year. These records, which are referred to as grievance registers, may be maintained on the

Appeals database and/or on any other appropriate record keeping system. The grievance registers will contain, at a minimum, the following information for each grievance:

1. A general description of the basis for the grievance using the categories set forth in the grievance procedure report.
2. The receipt date.
3. The date the grievance was investigated or reviewed.
4. The date the grievance was resolved.
5. A description of the grievance resolution.
6. The date the appeal, if any, was received.
7. The date of the appeals hearing or review.
8. The date the appeal was resolved.
9. A description of the resolution of the appeal.
10. The name of the Member or Member's representative, if any, who filed, or upon whose behalf was filed, the grievance.
11. The names and titles of all associates who investigated, reviewed, and resolved the grievance.
12. The name of the treating physician and facility rendering services, if any.

C. A separate grievance register will be maintained for insured HMO and POS Member grievances and insured PPO and Traditional Member grievances. These grievance registers will be retained until the later of the following two occurrences: (1) the Commissioner of the Indiana DOI has conducted an examination of the applicable business line and has adopted a final report of the examination that contains a review of the register for the calendar year(s) covered by the examination; or (2) Anthem's applicable record retention period ends.

D. Other logging and recording requirements: All grievances and appeals filed by Members shall be logged on the Appeals Database. For purposes of the Appeals Database, grievances may be logged as Level 1 Appeals and appeals will be logged as Level 2 Appeals.

IV. NOTICE TO ENROLLEES

A. Certificates of coverage: The Certificates of Coverage which Anthem provides to Members will contain the following information about the grievance process:

1. Information about the grievance procedures available to Members.
2. The toll free telephone number(s) and address at which a grievance may be filed.

B. Certificates will also contain the following information that pertains to but is not directly related to the Grievance Procedures:

1. A description of in-plan and out-of-plan covered services.
2. A description of limitations on payments for coverage of health care services, including commonly used definitions.
3. The criteria used to deny coverage, including a description of all exclusions.
4. An explanation of any limitations on coverage for experimental treatment, procedures, drugs or devices.

5. A description of the process used to determine any limitation, and a description of the criteria Anthem uses to determine whether a treatment, procedure, drug or device is experimental.
6. Information about where additional information on access to services can be obtained.
7. Information about the health maintenance organization's structure if the product is an insured HMO or POS product.
8. Information about costs for which the enrollee is responsible.
9. Information about financial incentives and disincentives given by Anthem to providers for the applicable product.

C. ID Cards and Other Notices: Information about the Member's right to file a grievance, including a toll free telephone number and address at which a grievance may be filed, will be included on any notice to enrollees regarding the provision, limitation, or denial of health care services. A toll free telephone number will also be displayed on the Member's identification card.

V. Toll Free Telephone Number

Anthem will maintain a toll free telephone number(s) through which grievances and appeals may be filed and information about Grievance Procedures obtained. An associate who is knowledgeable about Anthem's Grievance Procedures and any applicable state laws and regulations will be available to respond to calls received at the toll free telephone number(s) at least 40 normal business hours per week. At all other times, the toll free telephone number(s) will be answered by voice-mail. A qualified associate will respond to any messages left on voice-mail on the following business day. The toll free telephone number will accept grievances in English and other languages of major population groups served by Anthem.

VI. Acceptance and Handling of Grievances

A. Acceptance of grievances: Anthem will accept grievances filed orally, including by telephone, or in writing, including by facsimile. Grievances are any expressions of dissatisfaction expressed by or on behalf of a Member regarding the availability, delivery, appropriateness or quality of health care services, the handling or payment of claims for health care services or matters pertaining to the contractual relationship between Anthem and a Member or a group or individual contract holder. In order for an issue to qualify for acceptance as a grievance, the Member must have a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of the dissatisfaction. A grievance is considered filed on the day it is first received orally or in writing at the toll free telephone number and/or address through which Members were notified that a grievance may be filed. Grievances must be filed not later than 180 days after the Member received notice of the initial incident giving rise to the grievance unless the applicable Certificate of Coverage provides for a longer time period.

B. Member Representatives: Members may designate another person, including a health care provider, to file a grievance on their behalf. If a grievance on the Member's behalf is received from a person other than the Member, Anthem will research the grievance but may respond only to the Member unless a signed Designation of Representation form is received or unless the grievance is filed by a provider and qualifies for review

as an expedited grievance. Any provider who files an expedited grievance on behalf of the Member will be deemed to be the Member's designated representative and correspondence concerning the grievance will be sent directly to the provider. The Designation of Representation form is attached as Attachment B. Anthem will not accept a request by a participating provider for additional reimbursement for services already rendered as a grievance on behalf of the Member if the Member has no financial responsibility for the charges in question.

C. Acknowledging grievances: Grievances from insured PPO and Traditional Members will be acknowledged orally or in writing within (5) business days of their receipt by an Appeals Specialist. Grievances from insured HMO and POS Members will be acknowledged orally or in writing within (3) business days of receipt by an Appeals Specialist.

D. Standards for timely review and resolution of grievances:

1. Time to resolve Pre- and Post-Service grievances: Grievances will be resolved within a reasonable period of time appropriate to the medical circumstances but not later than the earlier of **20 business days** or **30 calendar days** from receipt of the **grievance request** by Anthem unless they qualify for expedited review under section 4.5. If a grievance concerns an adverse determination by Anthem that a service is not medically necessary or is experimental or investigational (referred to as a "Clinical Issue") but does not qualify for expedited review, the grievance shall be resolved **and the response shall be sent** within the reasonable period of time appropriate to the medical circumstances but not later than the earlier of the **20th business day** or **30th calendar day** from receipt.

2. Delay in resolving a Post-Service grievance: If a Member's grievance cannot be resolved within 20 business days due to Anthem's need for additional information to adequately review and investigate the grievance and the grievance concerns a matter other than a Clinical Issue, Anthem will notify the Member in writing of a 10 business day extension. The notice of the extension will be sent to the Member on or before the 19th business day. The extension may occur when necessary information is requested from a non-network provider or from the Member and such information has not been received within 15 calendar days from the filing of the grievance. In the event the Member is notified of an extension, Anthem will resolve the Member's grievance within 30 business days from the date of receipt. If the requested information has not been received, a determination will be made based on the information in Anthem's possession. As stated above, grievances concerning Clinical Issues must be resolved and the response sent not later than the earlier of 20 business days or 30 calendar days from receipt of the grievance.

3. Expedited grievances: An expedited grievance is available if the Member is grieving a determination by Anthem that a service is not medically necessary or is experimental or investigational (referred to as a "Clinical Issue") and the service has not been rendered or is ongoing. A grievance will be an expedited grievance if the Member's treating physician (or any other physician with knowledge of the Member's medical condition) believes that the service or supply is urgently needed, or if Anthem determines that the grievance should be expedited. Urgently-needed care is that care which would seriously jeopardize the Member's life or health or which would subject the Member to severe pain that cannot be adequately managed if

delayed during the time required for non-expedited review. The procedures for handling expedited grievances are as follows:

a. Initiation of expedited grievances: An expedited grievance may be initiated orally or in writing. Either the Member or provider may request an expedited grievance if all eligibility requirements for expedited grievances are met. Additionally, Anthem applying a prudent lay person standard may determine that an appeal may be expedited.

b. Acceptance of additional information: Anthem shall accept oral or written comments, documents or other information relating to the grievance from the Member or the Member's provider by telephone, facsimile or other reasonable means.

c. Access to Physician Reviewer: Anthem will provide the Member's provider with reasonable access to a physician or other licensed provider (referred to as a "Physician Reviewer") who did not make the decision giving rise to the grievance within 1 business day of the request.

d. Notice of decision by telephone: Telephone notice of the decision will be provided as soon as possible given the medical urgency of the situation, but not later than 48 hours from Anthem's receipt of the expedited grievance.

e. Notice of decision by letter: Written notice of an adverse decision will be sent within 72 hours of Anthem's receipt of the expedited grievance. This written notice will be sent to the Member, the Member's physician or other ordering provider, and the facility rendering service, if applicable.

E. Reviewer requirements: Member grievances concerning any Clinical Issue or concerning issues requiring medical judgment will be reviewed by a Physician Reviewer. The Physician Reviewer who reviews the grievance must:

1. be a different reviewer than the one who made the Initial Decision;

2. hold a current, non-restricted license to practice medicine in the United States;

3. be board-certified in a specialty board approved by the American Board of Medical Specialties (for doctors of medicine) or the Advisory Board of Osteopathic Specialists for doctors of osteopathic medicine);

4. be a clinical peer in the same or similar specialty as the treating provider;

5. be oriented to the principles of Utilization Management and the American HealthCare Commission/URAC Health UM Standards; and

6. not be the subordinate of the reviewer who made the Initial Decision.

A Physician reviewer will meet the same or similar specialty requirement if the Physician Reviewer is in the same licensure category as the ordering provider and is in a same or similar specialty as typically treats the medical condition, procedure or treatment under review. All other grievances will be handled by an associate with the experience, knowledge and training necessary to appropriately resolve the grievance.

F. Communicating the decision after a grievance is decided: Written notice of grievance decisions will be sent to the Member within 5 business days of the decision. If the grievance concerned a Clinical Issue, the response may need to be sent sooner in order to meet the time frames set forth in Section **D** 1. If the grievance qualified for expedited review, the response needs to be sent in accordance with the time frames set forth in Section **D** 3. If a representative of the Member filed the grievance, the letter will be sent to the representative as long as the Member returns a signed Designation of Representation form to Anthem or the grievance was expedited. The decision letter will:

1. State Anthem's understanding of the Member's grievance.
2. Describe in clear terms Anthem's grievance decision.
3. State the contract basis or medical rationale for the decision and, if applicable, include instructions for requesting a free copy of any internal rule, guideline, protocol or other similar criterion or policies that were used in making the decision.
4. Refer to the evidence or documentation used as the basis for the resolution.
5. Provide a description of further appeal rights including directions on how to file an appeal.
6. Identify the title of the person who made the decision.
7. If a medical or vocational expert was consulted with respect to the adverse determination that is being grieved, provide the Member with instructions on how to submit a written request for the names of the medical or vocational experts.
8. Identify the department, address and telephone number at Anthem through which the Member may contact an Appeals Specialist to ask questions about the grievance decision or to obtain additional information about further appeal rights.
9. Notify the Member of their right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to the Member's appeal and, if applicable, the Member's right to request, in writing, the name(s) of any medical or vocational expert(s) who rendered an opinion in connection with their appeal.

VII. Acceptance and Handling of Appeals of Grievance Determinations

A. Acceptance of Appeals: If the Member is dissatisfied with Anthem's grievance decision, the Member has the right to file an appeal. Anthem will accept appeals filed orally, including by telephone, or in writing, including by facsimile. An appeal is considered filed on the day it is first received orally or in writing by any business unit at Anthem. Appeals must be filed within 180 days of the Member's receipt of Anthem's grievance determination.

B. Acknowledging Appeals: Appeals filed by insured PPO and Traditional Members will be acknowledged orally or in writing within (5) business days of receipt by an Appeals

Specialist. Appeals filed by insured HMO and POS Members will be acknowledged orally or in writing within (3) business days of receipt by an Appeals Specialist.

C. Timely review of Appeals: Appeals of Clinical Issues that meet the definition of an expedited grievance will be resolved as expeditiously as the medical condition requires and Panel administration permits. Expedited Appeals filed by insured HMO and POS Members shall be resolved no later than 3 calendar days after receipt of the Appeal by Anthem. Appeals of Clinical Issues concerning adverse precertification, concurrent utilization review or case management determinations that do not qualify for expedited review will be resolved within 30 calendar days. All other appeals by insured HMO and POS Members will be resolved within 30 business days of receipt by Anthem. All other appeals by insured PPO and Traditional Members will be resolved within 45 business days of receipt by Anthem. Written notice of the appeal decision will be sent to the Member within five (5) business days of the decision.

D. Appeal Panel:

1. Appeals will be reviewed and resolved by a panel of associates with authority to bind Anthem. For Appeals of Clinical Issues and all Appeals by HMO and POS Members, the Panel will consist, at a minimum, of a Physician Reviewer and one other qualified reviewer. For all other Appeals, the Panel will consist, at a minimum, of two qualified reviewers.

2. A representative of Legal Services may be present at panel meetings, but will not have voting rights. Representatives from Medical Policy, Utilization Management and Network Management may participate in any panel meeting and, if they do, will be considered voting members.

3. A representative from Quality Improvement may also participate in Panel meetings as a non-voting panelist. If a Quality Improvement representative is not available, all quality issues identified by the panel will be forwarded to Quality Improvement for handling.

4. Other associates may also be invited to participate as non-voting members of the panel to help with a particular case or session of the panel.

5. Voting members of the panel will not have a material professional, familial or financial conflict of interest with the Member or, if applicable, with the provider who proposed, refused or delivered the service that was the basis of the underlying grievance.

6. Voting members cannot have rendered an opinion on the issue giving rise to the underlying grievance or during the investigation or resolution of the underlying grievance.

7. If the appeal is concerning a Clinical Issue, the provider appointed to represent the Medical Director area on the panel will have knowledge in the medical condition, procedure or treatment at issue and will be in the same licensed profession as the health care provider who proposed, refused or delivered the service that was the basis of the underlying grievance.

8. For appeals of Clinical Issues that are filed by insured PPO and Traditional Members, a physician will be appointed to review the case and provide an opinion to the panel that is in a same or similar specialty as the health care provider who proposed, refused or delivered the service that was the basis of the underlying grievance.

E. Right to Personal Appearance: The Member or the Member's designated representative has the right to appear before the appeal panel in person or by telephone.

F. Right to Submit Additional Information: The Member or the Member's designated representative may submit oral or written comments, documents or other information relating to the appeal for consideration by the appeal panel whether or not the Member chooses to appear in person or by telephone.

G. Scheduling the Appeal Panel meeting: The panel will meet to hear Expedited Appeals as expeditiously as the Member's medical condition requires and panel administration permits. For insured HMO and POS Members, this meeting must take place within three calendar days from the date of the appeal request. The review will take place in person and during normal business hours if reasonably possible. The primary consideration in scheduling the panel meeting for Expedited Appeals will be to get the review completed and to provide the Member with a telephonic response in accordance with the time frames set forth in section VII. C. The panel will meet to review all other appeals during normal business hours and, to the extent reasonably possible, at a place convenient to Members who wish to appear before the panel in person or by telephone. Anthem will give the appealing Member at least 72 hours prior notice of the date and time at which his or her appeal will be reviewed unless the appeal is an Expedited Appeal.

H. Communicating the panel's decision: Written notice of the appeal panel's decision will be sent to the Member within five (5) business days of the decision. If a representative of the Member filed the appeal, a copy of the letter will also be sent to the representative provided the Member has returned a signed Designation of Representation form to Anthem. The required contents of an appeals decision letter are the same as those for grievance appeal decisions in section VI. F, except that the areas represented by the panel rather than the title of panel Members will be disclosed and adverse appeal decision letters will notify Members of the external grievance process and their right to request an external grievance, if applicable, and their right to further remedies available at law.

VIII. Acceptance and Handling of External Grievances

A. Acceptance of and eligibility for external grievances: If a Member is dissatisfied with the appeal panel's determination, the Member has the right to request external review of their appeal by an independent review organization (IRO) provided all of following requirements have been met:

B. The Member's appeal is regarding:

1. An adverse utilization review/appropriateness determination;

2. An adverse determination of medical necessity; or

3. A determination that a proposed service is experimental or investigational made by Anthem or an agent of Anthem regarding a service proposed by the treating physician.

C. The Member or the Member's representative requests the external review in writing no later than **180 days** after the enrollee is notified of the appeal panel's appeal determination, unless the Member's certificate of coverage provides a longer time period;

D. The proposed service is not specifically excluded or identified as non-covered in the Member's Certificate of Coverage; and

E. The Member has not already filed an external grievance regarding the appeal determination at issue.

F. Anthem will accept external grievances filed orally, including by telephone, or in writing, including by facsimile or electronic means of communication.

G. Availability of external grievances before the Appeals Panel determination – Anthem option to elect bypass of internal Appeal levels: Anthem may elect to bypass any or all of the internal levels of review by sending a case straight to an IRO for review as an external grievance. Any levels of review which are bypassed are not later available except that insured HMO and POS Members will have the right to one level of the internal Appeal if Anthem did not obtain the insured HMO or POS Member's permission to bypass.

H. Selection of an Independent Review Organization: Upon receipt of the Member's request for an external grievance, Anthem will select an IRO to review the grievance from a list of IROs certified by the Indiana DOI. Anthem will rotate the choice of IRO among all certified IROs before repeating a selection. The IRO will assign a reviewer who is board certified in the applicable specialty. The IRO reviewer may not have a conflict of interest and must apply standards based on objective clinical evidence and the terms of the Member's benefit contract.

I. Signed Designation of Representation from the Member: If a representative of the Member is requesting the external grievance and Anthem does not already have a signed Designation of Representation form on file for the representative, Anthem will ask the Member to complete a Designation of Representation form. The Designation of Representation form, if applicable, will be forwarded to the Member along with a return envelope addressed to the Appeals Specialist. For purposes of determining the time frames for resolving external grievances, an external grievance will be considered filed on the date the request for external grievance is received. An external grievance will not be delayed if the Member fails to return a Designation of Representation form; however, all communications will be sent to the Member until the Designation of Representation form is signed by the Member and returned to Anthem.

J. Records provided to the IRO: Anthem will provide all relevant information gathered during the internal appeals process to the selected IRO. The record provided by Anthem to the IRO should include:

1. Questions for the IRO to answer that are based on the Member's Certificate of Coverage;

2. A copy of the language from the Certificate of Coverage on which Anthem's decision is based;

3. A copy of pertinent records from the Member's Appeal file; and

4. Copies of the criteria or policies on which Anthem's decision was based.

5. Anthem will also provide the IRO with any additional information in its possession that the IRO may request.

K. Time frames for completing the external grievance: For expedited external grievances, the IRO will make its determination within 72 hours of receipt. An external grievance will be expedited if it relates to an illness, disease, condition, injury, or disability that could seriously jeopardize the Member's life or health, or ability to reach and maintain maximum function. For all other external grievances, the IRO will make its determination within fifteen (15) business days after the external grievance is filed.

L. Reconsideration by the Appeal Panel: In the event that the Member submits new information to Anthem that is relevant to Anthem's resolution of the Member's appeal while the IRO is conducting the external grievance, Anthem will notify the IRO to cease its review until the appeal panel reconsiders its appeal determination. The appeal panel will schedule a time to meet, either in person or by conference call, to reconsider its appeal determination. If the IRO was conducting an expedited external grievance when the information was submitted, the panel will make a determination and Anthem will notify the Member of its decision by telephone within seventy-two (72) hours after the information is submitted. In all other cases, the panel will make a determination and Anthem will notify the Member of its decision by telephone within fifteen (15) calendar days after the information is submitted. Within two (2) calendar days after the decision is made, a letter will be sent to the Member confirming the panel's decision. If the panel's decision is to overturn the adverse determination, a copy of the letter will also be sent to the IRO along with a written request that the IRO close its file on the matter. If the panel's decision is to uphold the adverse determination, the letter will notify the Member of the Member's right to request that the IRO resume its external review. We will forward the submitted information to the IRO within two (2) business days after receipt of information if the decision is made not to reconsider the new information.

M. Notification of the IRO's determination: The IRO shall notify the Plan and member of their decision within 72 hours of making the determination for standard appeals and within 72 hours after an expedited appeal is filed. If the IRO makes a determination to reverse the appeal panel's decision, then Anthem will take all steps necessary to overturn the adverse determination. Anthem will notify the Member, in writing, of the steps that have been or will be taken to comply with the IRO's determination.

N. External grievance reporting requirements: On or before March 1 of each year for its insured HMO and POS business and beginning March 1, 2003 for its insured PPO and

Traditional business, Anthem will file a description of its external grievance procedure with the Indiana DOI, including: .

1. The total number of external grievances handled through the procedure during the preceding calendar year;

2. A compilation of causes underlying those grievances; and

3. A summary of the final disposition for each IRO used during the reporting year.

O. Annual Notice of External Review Rights: Anthem will send members a general notice of the availability of External Review annually through a member newsletter, an updated benefit plan document or other similar communication method.

IX. Grievances and Appeals by Insured Members of Plans Subject to Erisa (Erisa Members)

A. Mandatory Appeals: ERISA insured Members must file a grievance concerning an adverse determination prior to bringing a civil action under section 502(a) of ERISA. All other available internal appeal levels will be considered voluntary. State mandated external grievances will not be considered voluntary appeal levels for fully insured members.

B. Voluntary Appeals – Basic Principles: With respect to voluntary levels of internal appeal, Anthem:

1. waives any right to assert that an ERISA insured Member failed to exhaust administrative remedies because the ERISA Member did not elect to file any voluntary level of internal Appeal that was available;

2. agrees that any statute of limitations or other defense based upon timeliness is tolled during the time that any voluntary appeal is pending;

3. will provide to any ERISA insured Member, upon request, sufficient information relating to any voluntary levels of appeal to enable the ERISA insured Member to make an informed judgment about whether to file a voluntary level of appeal. This information shall include a statement that the decision as to whether or not to file a voluntary appeal will have no effect on other benefits under the plan and information about the applicable rules, the ERISA insured Member's right to representation, the process for selecting the decision maker(s) and the circumstances, if any, that may affect the impartiality of the decision maker.

C. Cost to the Member: Anthem shall not impose any costs or fees on ERISA insured Members as part of a voluntary level of appeal.

D. Availability of Voluntary Appeal Levels: ERISA insured Members may file a voluntary appeal only after the grievance level of review has been exhausted.

E. Additional Grievance Decision Letter Contents: Grievance denial letters sent to ERISA Members shall include the following in addition to the content requirements contained in Section VI. F:

1. a statement describing any voluntary appeal procedures offered by the plan and the ERISA Member's right to obtain information about such procedures;

2. A statement of the ERISA Member's right to bring an action under section 502(a) of ERISA.

X. Network Provider Appeals

1. Providers have one level of internal appeal. They may not appeal contracted reimbursement rates, bundling or coding issues. These issues will be handled by Provider Services as an inquiry.
2. Clinical appeals must be filed within 180 days of the adverse determination.
3. Provider post-service appeals will be completed within 60 calendar days.
4. If a denial is based in part or in whole on a medical judgment, our notice of determination will include:
    a. Any guideline, policy provision, internal rule, protocol, or other similar criteria used in making the determination, and its title
    b. Qualifying credentials of the person(s) conducting the medical review
    c. Their right to a copy of all applicable guidelines used.

Policy History

Date Issued	02/01/00	**Changes**	**Initials**
Reviewed			
Revised	03/11/14	The Member or the Member's representative requests the external review in writing no later than 120 days after the enrollee is notified of the appeal panel's appeal determination, unless the Member's certificate of coverage provides a longer time period.	AF
Revised	03/24/16	Updated the timeframes for completing an external grievance.	AF/EW/RS
Revised	06/02/16	Added revised IRO timeframes as follows: The IRO shall notify the Plan and member of their decision within 72 hours of making the determination for standard appeals and within 72 hours after an expedited appeal is filed.	AF/Policy Team
Revised	6/20/2016	Changed provider appeals section and added addendum	EW/KS/Policy team
Revised	11/13/2018	Appeals must be filed within 180 days of the Member's receipt of Anthem's grievance determination. Provider clinical appeals must be filed within 180 days of the adverse determination. The Member or the Member's representative requests the external review in writing no later	AF/KL

		than **180 days** after the enrollee is notified of the appeal panel's appeal determination, unless the Member's certificate of coverage provides a longer time period.	
Revised	01/31/2019	Changed authorizing signature to Lisa Byrd, Staff VP, G&A. Added that written notice of the appeal decision will be sent to the Member within five (5) business days of the decision.	AF
Revised	02/21/2020	Changed authorizing signature to Rebecca Harbottle, Staff VP, G&A	JH

Approval History

Approvers	Date	Revision Date(s)	Comments
Policy Requestor			
Policy Review Committee			Policy Creation Team
G&A Legal Team (if applicable)			
Medical Directors (if applicable)			
State Specific Quality Committees (If applicable –please specify below)			
Enterprise Service Quality Committee (if applicable)			
Other			

References:
Indiana Department of Insurance

Attachement:
Indiana Appeals Attachement with Member Rights

Indiana Appeals Attachment

Rights Available to Members

If you don't agree with this decision, you have the right to ask for a grievance (also known as an appeal). You must ask for a grievance within 180 calendar days from the date you get this letter. Your doctor, or any other person you choose (your authorized representative), may act on your behalf. A person of your choice may also help you during the grievance process. You need to let us know, in writing, if you want someone to act on your behalf or help you.

How do I ask for an urgent (expedited) grievance?

You may ask for an urgent grievance if you, or your health care provider, believe that your condition could:

- Seriously jeopardize (harm) your life, health, or ability to regain maximum function; or
- Would subject you to severe pain that can't be adequately managed without care or treatment while waiting for the grievance to be resolved using standard time frames.

An urgent grievance isn't available if you've already had the services.

We will let you know the decision within 48 hours after we get an urgent grievance. We will let you know the decision by phone. We will also send you the decision in writing.

You may simultaneously ask for an urgent independent external review if your situation is urgent. This means that you may ask for an urgent grievance with us and an urgent external review by an Independent Review Organization (IRO) at the same time.

You can ask for an urgent grievance or an urgent external review in writing or by phone:

In writing:	Anthem Blue Cross and Blue Shield Grievances and Appeals P.O. Box 105568 Atlanta, GA 30348-5568
By phone:	1-800-325-3377

While your request may be in writing, we strongly encourage you to call Member Services to ask for an urgent grievance or urgent external review.

How do I ask for a standard (not expedited) grievance?

You may ask for a standard grievance in writing. You may also ask for this review by phone or online.

In writing:	Grievances and Appeals P.O. Box 105568 Atlanta, GA 30348-5568
By phone:	Call Member Services at the phone number on your member ID card.
Online:	www.anthem.com

We will respond to your standard grievance within 20 business days or 30 calendar days from the date we get the request, whichever is sooner.

What should my grievance include?

Include (if you are able to):

- The member's name and ID number;
- The name of the provider who will or has provided care;
- The date(s) of service;
- The claim or reference number for the specific decision with which you don't agree; and
- The specific reason(s) why you don't agree with the decision.

You have the right, and we encourage you, to give us written comments, documents and other relevant information with your grievance.

Who will review my grievance?

The appropriate administrative and/or clinical reviewers will look at your grievance. They will not have been involved in the initial decision. They also will not be a subordinate (in a position of less power or authority) of the person who made the initial decision. All relevant information sent by you or on your behalf will be looked at. It will be looked at even if it was taken into account when the initial decision was made. We may reach out to any providers (doctors) who may have information to support your grievance.

If I don't agree with the grievance decision, what other rights do I have?

You may have the right to ask for an appeal. You may also have the right to ask for an external review with an Independent Review Organization (IRO) within 180 days from the date you get a grievance decision from us that you don't agree with. We will give you more details if we deny your grievance.

You have the right to file a complaint with the Indiana Department of Insurance. You may reach them in writing or by phone:

In writing: Consumer Services Division
Indiana Department of Insurance
311 West Washington Street, Suite 300
Indianapolis, IN 46204-2787

By phone: 1-317-232-2395 (locally) or 1-800-622-4461 (toll-free)

What if I need more information about my grievance rights?

Call us at 1-800-325-3377. You may also look at your benefits booklet or call Member Services at the phone number on your member ID card.

ERISA Plan Members

If your health benefit plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), and you have exhausted all mandatory appeal rights, you have the right to bring a civil action in federal court under section 502(a)(1)(B) of ERISA.

Anthem.

Grievances and Appeals for Health Plan Members and Providers- Indiana

Title: Appeal for Health Plan Members Policy – IN Addendum	**Effective Date**: February 7, 2012
Last Revision Date: 01/31/19	**Last Review Date:** 02/21/20
Distribution: Indiana G&A Management and Associates	**Authorization**: Rebecca Harbottle, Staff VP, Grievances and Appeals

I. Provisions

A. In conjunction with the Enterprise Grievance and Appeal for Health Plan Members Policies (Umbrella Policy) and the Appeal Process Addendum, this document complies with the requirements of the Indiana Department of Insurance (IDOI) and applicable statutes of the State of Indiana for conducting appeals.

B. The definitions contained in the Umbrella Policy are for enterprise consistency and internal purposes. Definitions notwithstanding, our processes and reporting will comply with the Indiana requirements.

C. The Insurer is mandated to provide: notice of the appeal process, the external appeal process and instructions on how to file an appeal including external appeals. The notice must include a toll free number to contact a representative to assist in answering questions and filing an appeal.

D. The initial adverse clinical determination will include the address and telephone number where a covered person may contact a qualified representative to obtain more information regarding the adverse determination or the right to an appeal. The notice is to also include a toll-free phone number to receive verbal appeals.

E. The appeals process applies to pre-service, concurrent and post-service denials.

F. The member has the right to contact the IDOI at any time.

G. This policy applies to all group and individual insurance policies or certificates issued in the State of Indiana by Anthem Blue Cross and Blue Shield (the Plan).

H. As stipulated herein, this policy also applies to Providers acting on their own behalf for post-service benefit determinations for which the member is held harmless. This policy shall not be construed to provide Participating Providers with any additional rights or remedies in lieu of or in addition to those set forth in the Participating Provider's agreement.

II. Policy

Fully insured group members have two levels of internal appeal. Upon completion of the first level, group members may proceed with the second level appeal or request an external review for qualifying adverse determinations. An ERISA eligible group member may take legal action against the plan upon completion of the first level appeal, Civil Action 502A ERISA.

Individual policy members have one level of internal appeal and may request an external review for qualifying adverse determinations.

Self-insured groups may choose to follow their own appeal process. This process could include: assuming responsibility of reviewing their own appeals, having Anthem review only one level of appeal while they review the other, or having Anthem conduct the entire review. Always refer to the description of benefits to determine the correct appeal process.

Participating Network Providers have one level of appeal for qualifying adverse benefit decisions but cannot request external appeals.

Please refer to the group's specific description of benefits for any variation of the process described below.

A. First Level Internal Appeal – Members

Please refer to the group's specific description of benefits for any variation of the process described below.

1. Members have 180 days from the initial adverse determination to file an appeal.
2. Written acknowledgment shall be provided within **five business days** of receipt of request for appeal **for PPO/ traditional** policy members and within **three business days for HMO/POS** policy members.
3. The appeal will be resolved within 20 business days, not to exceed 30 business days in the event of an extension, of our receipt of the appeal unless otherwise stated in the description of benefits. A written response to the appeal will be issued within 5 business days of the decision.
    a) If a standard appeal cannot be resolved within 20 business days, due to circumstances beyond the Plan's control, the covered person may agree to an extension of up to ten business days for the final determination. Anthem must notify the member in writing by the 19th business day explaining the reason for the delay. Decision and notification will be issued within ten business days of the extension notice.
4. Determination and verbal notification for appeals qualifying for expedition will be completed within 48 hours of receipt of sufficient information to conduct an appeal. Written notification of the decision must be issued within 72 hours of receipt of the appeal.

5. The following modification to the adverse determination requirements identified in the Appeal Process Addendum will apply to appeals handled for Indiana members:

    a) Identify the department, address and telephone number at Anthem through which the Member may contact a qualified representative to ask questions about the appeal decision or to obtain additional information about further appeal rights.

B. Second Level Voluntary **Internal Appeals – Members**

1. Second level internal appeals may not be requested if the member opted to pursue an external review following the denial of a level one appeal.
2. Members have 60 calendar days from the adverse determination of the first level appeal to file their request for a second level appeal.
3. An acknowledgment shall be provided within **five business days** of receipt of request for appeal for **PPO/ traditional** policy members and within **three business days for HMO/POS** policy members.
4. Members will be advised of their right to appear, either in person or via other means, such as teleconference, before the appeal panel conducting the second level appeal.
5. Members or their designee may also submit oral or written comments, documents or other information relating to the appeal for consideration by the appeal panel whether or not the member chooses to appear.
6. The member shall be notified of the meeting date and time not less than 72 hours prior to the meeting of the panel.
7. A panel of at least one qualified reviewer shall be appointed to resolve the second level appeal. The qualified reviewer shall have knowledge of the medical condition, procedure, or treatment at issue, shall not be involved in the matter giving rise to the appeal or in the initial investigation of the appeal, and shall not have a direct business relationship with the member or the health care provider who previously recommended the health care procedure, treatment, or service under review.
8. The second level panel will be scheduled to occur and a decision made within:

    a) 45 business days of receipt for non-managed care ASO and fully insured administrative appeals.

    b) 30 business days of receipt for managed care ASO and fully insured administrative appeals.

    c) 30 calendar days of receipt for all clinical appeals

9. A written response to second level internal appeals will be issued within 5 business days of the decision.
    a) The required contents of an appeal decision letter are the same as those of first level decision letters, with the exception that the areas represented by the panel rather than the title of panel participants will be disclosed.
    b) When applicable, adverse appeal decision letters will include notification of the external appeals process, member's right to request an external appeal and their right to further remedies available by law.
10. Second level appeals qualifying for expedition will be reviewed by the panel immediately and a verbal response issued within 24 hours followed by a written response in three days.

C. Independent External Review – Members

1. Members of fully funded group or individual plans, as well as members of self-funded non-ERISA groups under the jurisdiction of the IDOI may be eligible for the mandated Independent External Review (IER) process overseen by the IDOI. In order to be eligible for IER, the issue must be an adverse determination based on medical necessity, experimental/investigational services, or the existence of a pre-existing condition. The IER is an optional process for the member and is not required to demonstrate fulfillment of the Plan's internal appeals process. Self-funded groups not under the jurisdiction of the IDOI may be eligible for the federally mandated IER as outlined in the policy titled, *Health Care Reform Protection and Affordability Care Act External Review.*
2. Administrative denials, such as benefit maximum or policy exclusions, are not eligible for independent external review.
3. A member has 45 calendar days from the second level appeal decision to submit their request for independent external review. An Independent Review Organization (IRO) will be selected on a rotational basis from a list that is approved by the IDOI.
4. The IRO shall complete its review within 15 business days of receipt of requests for standard reviews and within three business days for expedited reviews.
    a) The IRO shall notify the Plan and member of their decision within 72 hours of making the determination for standard appeals and within 72 hours after an expedited appeal is filed.

5. If additional information is submitted by the member at any time during the external review process, the new information may be considered for internal review and the IRO shall cease the external review until the reconsideration is completed.
    a) The member shall be notified of the decision based on the new information within 72 hours of receipt of that information for expedited appeals and within 15 calendar days for standard reviews.
    b) If the decision reached is still an adverse determination, the member may request that the IRO continue its review. The submitted information will be forwarded to the IRO within two business days after receipt of the information if the decision is made not to reconsider the new information.

D. Network Provider Appeals

1. Providers have one level of internal appeal. They may not appeal contracted reimbursement rates, bundling or coding issues. These issues will be handled by Provider Services as an inquiry.
2. Providers have180 days from the initial adverse determination to file a clinical appeal.
3. The provider does not have the right to file an appeal for administrative issues.
4. Provider clinical appeals will follow the same process as first level member appeals. The written decision letter will be issued within 20 business days not to exceed 30 calendar days of our receipt of the appeal, unless otherwise stated in the Description of Benefits. The provider has one level of appeal for clinical issues. For post-service clinical appeals, the written decision letter will be issued within 60 calendar days of our receipt of the appeal.
5. If a denial is based in part or in whole on a medical judgment, our notice of determination will include:
    a) Any guideline, policy provision, internal rule, protocol, or other similar criteria used in making the determination, and its title
    b) Qualifying credentials of the person(s) conducting the medical review
    c) Their right to a copy of all applicable guidelines used.

Policy History

Date Issued	February 7, 2012	**Changes**	**Initials**
Reviewed	February 8, 2013	None	Policy Team
Revised	1/7/15	Changed company name from WellPoint to Anthem	AF
Revised	5/26/16	Revision made to IRO timeframe: "The IRO shall notify the plan and member of their decision within 72 hours after an expedited appeal is filed.	AF/Policy Team
Revised	3/20/17	Changed authorizing signature to Dianne Crump from Toni Schiavo.	AF
Revised	11/02/18	Removed statement that providers can file an administrative appeal. Added members have up to 180 days from initial adverse determination to file an appeal. Added that providers have up to 180 days from the initial adverse determination to file a clinical appeal. The timeframe to resolve post-service clinical appeals is 60 calendar days.	AF/KL/Policy Team
Revised	01/31/19	Changed authorizing signature to Lisa Byrd, Staff VP, G&A. Added that a written response to the appeal will be issued within 5 business days of the decision.	AF
Revised	2/21/20	Changed authorizing signature to Rebecca Harbottle, Staff VP, G&A.	JH

Approval History

Approvers	Date	Revision Date(s)	Comments
Policy Requestor			
Policy Review Committee			Policy Creation Team
G&A Legal Team (if applicable)			
Medical Directors (if applicable)			
State Specific Quality Committees (If applicable –please specify below)			

Enterprise Service Quality Committee (if applicable)			
Other			

References:
Indiana Department of Insurance
Indiana Code 27-8-28-16