INDIANA GRIEVANCE PROCEDURES

I. DEFINITIONS

A. *Authorized representative* means:
  1. A person to whom a *covered individual* has given express written consent to represent the *covered individual*;
  2. A person authorized by law to provide substituted consent for a *covered individual*; or
  3. A family member of the *covered individual* or the *covered individual*'s treating health care professional when the *covered individual* is unable to provide consent.
  4. For purposes of these procedures a reference to a *covered individual* may also refer to an *authorized representative*.

B. "*Circumstances beyond the insurer's control*" means:
  1. The failure of a provider that is not a participating provider to provide within 15 days of the filing of the *grievance* information that is requested by the insurer and is necessary to adequately review and investigate the *grievance*; or
  2. The failure of a *covered individual* to provide additional information requested by the insurer that is necessary to resolve the *grievance* within 15 days of the filing of the *grievance*.

C. "*Covered individual*" means an individual who is covered under an accident and sickness insurance policy. For purposes of these procedures, a *covered individual* may also include:
  1. An *authorized representative*; and
  2. A person acting on behalf of the *covered individual*.

D. "*Grievance*" means any dissatisfaction expressed by or on behalf of a *covered individual* regarding:
  1. A determination that a service or proposed service is not appropriate or medically necessary;

2. A determination that a service or proposed service is experimental or investigational;
3. The availability of participating providers;
4. The handling or payment of claims for health care services;
5. Matters pertaining to the contractual relationship between:
   a. a *covered individual* and an insurer; or
   b. a group policyholder and an insurer;
6. An insurer's decision to *rescind* an accident and sickness insurance policy; or
7. A determination concerning a *prior authorization* request;

and for which the *covered individual* has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

D. *Post-service claim* means any claim for benefits for medical care or treatment that is not a *pre-service claim.*

E. "*Preceding prescription drug*" means a prescription drug that, according to a *step therapy protocol,* must be:
   1. First used to treat a *covered individual*'s condition; and
   2. As a result of the treatment under subdivision (1), determined to be inappropriate to treat the *covered individual*'s condition;

   as a condition of coverage for succeeding treatment with another prescription drug.

F. *Pre-service claim* means any claim for benefits for medical care or treatment that requires the approval of the insurer in advance of the *covered individual* obtaining the medical care.

G. "*Prior authorization*" means a practice implemented by an insurer through which coverage of a health care service is dependent on the *covered individual* or health care provider obtaining approval from the insurer before the health care service is rendered. The term includes prospective or *utilization review* procedures conducted before a health care serve is rendered.

H. "*Protocol exception*" means a determination by an insurer that, based on a review of a request for the determination and any supporting documentation:
   1. A *step therapy protocol* is not medically appropriate for treatment of a particular *covered individual*'s condition and
   2. The insurer will:
      a. Not require the *covered individual*'s use of a *preceding prescription drug* under the *step therapy protocol*; and
      b. Provide immediate coverage for another prescription drug that is prescribed for the *covered individual*.

I. *Rescind* means the insurer retroactively cancels or discontinues insurance coverage or an insurance policy.

J. *"Step therapy protocol"* means a protocol that specifies, as a condition of coverage, the order in which certain prescription drugs must be used to treat a *covered individual*'s condition.

K. *Urgent care claim* means:
   1. Any claim that a physician with knowledge of the *covered individual*'s medical condition determines is an *urgent care claim* to which the application of the time

periods for making non-urgent care determinations could seriously jeopardize the life or health of the *covered individual* or the ability of the *covered individual* to regain maximum function.

2. In the opinion of a physician with knowledge of the *covered individual*'s medical condition, any claim for medical care or treatment where the application of the time periods for making non-urgent care determinations would subject the *covered individual* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
3. Any claim for medical care or treatment where the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the *covered individual* or the ability of the *covered individual* to regain maximum function. Whether a claim is an *urgent care claim* will be determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

L. "*Utilization review*" means a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services provided or proposed to be provided to a *covered individual*. The term does not include:
   1. Elective requests for clarification of coverage, eligibility, or benefits verification; or
   2. Medical claims review.

M. "*Utilization review determination*" means the rendering of a decision based on *utilization review* that denies or affirms either of the following:
   1. The necessity or appropriateness of the allocation of resources; or
   2. The provision or proposed provision of health care services to a *covered individual*.

   The term does not include the identification of alternative, optional medical care that requires the approval of the *covered individual* and does not affect coverage or benefits if rejected by the *covered individual*.

II. ASSISTANCE

A. A toll free telephone number is available for a *covered individual* to obtain information about filing *grievances*.
   1. The individuals that answer the toll free telephone number can assist the caller or forward the call to the appropriate department if additional information is needed.
   2. Calls can be received at least 40 normal business hours per week and at other times the calls will be recorded by voicemail.
   3. If a call is left on voicemail, a qualified individual will respond to the call the next business day after the call is received.
   4. The calls will be answered by individuals who speak the English language. Non-English languages will be translated through a third party translation service.

B. Assistance is also available for *covered individuals* with literacy, physical, health, or other impediments.

III. INTERNAL REVIEW OF A DENIED *PROTOCOL EXCEPTION* REQUEST FOR STEP THERAPY

A. General Information:
   1. *Covered individual*s have the right to submit written comments, documents, records, and other information relating to the claim for benefits.
   2. *Covered individual*s have the right to review the claim file and to present evidence and testimony as part of the internal review process.
   3. A c*overed individual* shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the c*overed individual*'s claim for benefits.
   4. All comments, documents, records and other information submitted by the c*overed individual* relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial review, will be considered in the internal review.
   5. Review of the appeal will be conducted by an individual selected by the insurer who was not the individual who made the initial determination and is not the subordinate of the original reviewer.
   6. An insurer providing benefits for an ongoing course of treatment is required to provide continued coverage pending the outcome of an appeal. This means that an insurer cannot reduce or terminate benefits without providing advance notice and an opportunity for advance review.

B. Standard Request: A *covered individual* may appeal a denial of a *protocol exception* request orally or in writing.

C. Expedited Request: If either of the following situations are met, an expedited review may be requested:
   1. If medical care or treatment is not provided earlier than the timeframe generally considered by the medical profession to be reasonable for a nonurgent situation, the injury or condition could seriously jeopardize the *covered individual*'s life, health, or ability to regain maximum function, based on a prudent layperson's judgment; or
   2. If medical care or treatment is not provided earlier than the timeframe generally considered by the medical profession to be reasonable for a nonurgent situation, the injury or condition could subject the *covered individual* to severe pain that cannot be adequately managed, based on the *covered individual*'s treating health care provider's judgment.

D. Reviewer's Requirements:
   1. If supporting clinical information accompanies the appeal request, refer the case to the medical director or external medical reviewer for a clinical review to determine if a *protocol exception* should be granted.
   2. If there is not supporting clinical information accompanying the appeal request and a reasonable amount of time exists to meet the timeframe requirement, request the clinical information from the *covered individual* or provider. If not enough time exists to meet the timeframe, refer the case with the information received to the medical director or external medical reviewer for a clinical review to determine if a *protocol exception* should be granted.
   3. A *protocol exception* will be granted if any of the following apply:

a. A *preceding prescription drug* is contraindicated or will likely cause an adverse reaction or physical or mental harm to the *covered individual*
b. A *preceding prescription drug* is expected to be ineffective, based on both of the following:
   (1) The known clinical characteristics of the *covered individual*; and
   (2) Known characteristics of the *preceding prescription drug*, as found in sound clinical evidence;
c. The *covered individual* has previously received:
   (1) A *preceding prescription drug*; or
   (2) Another prescription drug that is in the same pharmacologic class or has the same mechanism of action as a *preceding prescription drug*;

   and the prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
d. Based on clinical appropriateness, a *preceding prescription drug* is not in the best interest of the *covered individual* because the *covered individual* 's use of the *preceding prescription drug* is expected to:
   (1) Cause a significant barrier to the *covered individual*'s adherence to or compliance with the *covered individual*'s plan of care;
   (2) Worsen a comorbid condition of the *covered individual*; or
   (3) Decrease the *covered individual*'s ability to achieve or maintain reasonable functional ability in performing daily activities.

E. Resolution Timeframe and Notification:
1. For standard reviews, a determination on an appeal of a denial of a *protocol exception* request must be made not more than **3 business days** after receiving the appeal.
   a. If the decision is provided orally, send a written notification of the decision within **5 business days**.
   b. Written notification of the decision must be sent to the *covered individual* and the treating health care provider.
2. For expedited reviews, a determination on an appeal of a denial of a *protocol exception* request must be made not more than **1 business day** after receiving the appeal.
   a. If the decision is provided orally, send a written notification of the decision within **5 business days**.
   b. Written notification of the decision must be sent to the *covered individual* and the treating health care provider.
3. If the determination is upheld or modified, the written notification must include:
   a. Detailed, written explanation of the reason for the denial;
   b. Reference to the specific plan provision on which the determination is based;
   c. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
   d. The claimant may have a right to bring a civil action under state or federal law;
   e. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline,

protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

f. The clinical rationale that supports the denial;
g. The date of service;
h. The health care provider's name;
i. The claim amount;
j. The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
k. The insurer's denial code with corresponding meaning;
l. A description of any standard used, if any, in denying the claim;
m. That assistance is available by contacting the specific state's consumer assistance department, if applicable;
n. A culturally linguistic statement based upon the claimant's county or state of residence that provides for oral translation of the decision, if applicable; and
o. The identification of medical experts whose advice was obtained on behalf of the insurer, without regard to whether the advice was relied upon in making the decision.

IV. INTERNAL REVIEW OF *GRIEVANCES* AND APPEALS (Not Including Step Therapy Denials)

A. General Information Applicable to *Grievance*s and Appeals

1. *Covered individual*s have the right to submit written comments, documents, records, and other information relating to the claim for benefits.
2. *Covered individual*s have the right to review the claim file and to present evidence and testimony as part of the internal review process.
3. A c*overed individual* shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the c*overed individual*'s claim for benefits.
4. All comments, documents, records and other information submitted by the c*overed individual* relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial review, will be considered in the internal review.
5. The c*overed individual* will receive from the insurer, as soon as possible, any new or additional evidence considered by the reviewer. The insurer will give the c*overed individual* 10 calendar days to respond to the new information before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the c*overed individual* will have the option of delaying the determination for a reasonable period of time to respond to the new information.
6. The c*overed individual* will receive from the insurer, as soon as possible, any new or additional medical rationale considered by the reviewer. The insurer will give the c*overed individual* 10 calendar days to respond to the new medical rationale before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the

c*overed individual* will have the option of delaying the determination for a reasonable period of time to respond to the new medical rationale.

7. Review of the *grievance* will be conducted by an individual selected by the insurer who was not the individual who made the initial determination and is not the subordinate of the original reviewer.
8. Review of the appeal will be conducted by an individual selected by the insurer who was not the individual who made the initial or *grievance* determination and is not the subordinate of the earlier reviewers.
9. An insurer providing benefits for an ongoing course of treatment is required to provide continued coverage pending the outcome of a *grievance* or appeal. This means that an insurer cannot reduce or terminate benefits without providing advance notice and an opportunity for advance review.
10. The internal review process must be exhausted before the c*overed individual* may request an external review unless:
    a. The insurer provides a waiver of this requirement;
    b. The insurer fails to follow the internal review process; or
    c. The c*overed individual* files an *urgent care claim* external appeal at the same time as a request for *urgent care claim* internal review.

B. <u>*Grievance*s</u>

1. Standard *Grievance* Review
    a. <u>Request</u>: A *grievance* may be submitted orally or in writing by the *covered individual* or on behalf of the *covered individual*.
    b. <u>Acknowledgment</u>: Within **5 business days** after receipt of a *grievance*, the insurer will provide the grievant and the *covered individual*, if they are not the grievant:
        (1) The name, address, and telephone number of an individual to contact regarding the *grievance*; and
        (2) The date the *grievance* was filed.
    c. <u>Reviewer's Requirements</u>:
        (1) A *grievance* regarding appropriateness, medical necessity, or experimental or investigational treatment will be evaluated by a health care professional chosen by the insurer, who was not involved in the initial determination.
        (2) A *grievance* regarding a rescission action will be reviewed by a panel of individuals who were not involved in the initial determination.
        (3) All other *grievances* will be reviewed by at least one individual who:
            (a) Was not involved in the making of the original determination;
            (b) Is not the subordinate of the original reviewer; and
            (c) Has sufficient experience, knowledge, and training to appropriately resolve the *grievance*.
    d. <u>Resolution Timeframe and Notification of Determination</u>:
        (1) For *pre-service claim*s, the *grievance* will be resolved as quickly as possible, but not more than 15 calendar days after receipt. The grievant and the *covered individual*, if they are not the grievant, will be notified in writing of the resolution of the *grievance* the earlier of 5 business days after the investigation is complete or 15 calendar days after the *grievance* is received.

(2) For *post-service claim*s, the *grievance* will be resolved as quickly as possible, but not more than 20 business days after receiving all information reasonably necessary to complete the review. If the insurer is unable to make a decision regarding the *grievance* within the 20 day period due to *circumstances beyond the insurer's control*, the insurer will notify the grievant and the *covered individual*, if they are not the grievant, in writing of the reason for the delay before the 20th business day. The insurer will then issue a written decision to the grievant and the *covered individual*, if they are not the grievant, within a total of 30 calendar days after receipt of the *grievance*, regardless of whether all information has been received. The insurer will notify the grievant and the *covered individual*, if they are not the grievant, in writing of the resolution the earlier of 5 business days after the investigation is complete or 30 calendar days after the *grievance* is received.

(3) The written decision will include the following:
   (a) A statement of the insurer's understanding of the *grievance*;
   (b) The decision reached by the insurer and the contract basis or medical rationale for the resolution stated in sufficient detail for the grievant and the *covered individual*, if they are not the grievant, to respond further to the insurer's position;
   (c) Reference to the evidence or documentation used as the basis for the resolution;
   (d) Notice of the right to appeal the decision; and
   (e) The department, address, and telephone number of the department handling the *grievance*, through which a qualified representative may be contacted to obtain additional information about the resolution and notice of any rights to further review.
   (f) A statement that the grievant and the *covered individual*, if they are not the grievant, is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the *covered individual*'s claim for benefits;
   (g) A statement that the *covered individual* may have a right to bring a civil action under state or federal law;
   (h) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the grievant and the *covered individual*, if they are not the grievant, upon request;
   (i) If the *adverse benefit determination* is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the *covered individual*'s medical circumstances, or a statement that such explanation will be provided free of charge upon request;
   (j) The date of service;

(k) The health care provider's name;
(l) The claim amount;
(m) The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
(n) The insurer's denial code with corresponding meaning;
(o) A description of any standard used, if any, in denying the claim;
(p) That assistance is available by contacting the specific state's consumer assistance department, if applicable;
(q) A culturally linguistic statement based upon the *covered individual*'s county or state of residence that provides for oral translation of the *adverse benefit determination,* if applicable; and
(r) The identification of medical experts whose advice was obtained on behalf of the insurer, without regard to whether the advice was relied upon in making the *adverse benefit determination.*

2. Expedited *Grievance* Review
   a. Request: An expedited *grievance* regarding an *urgent care claim* may be submitted orally or in writing.
   b. Transmission of Information: All necessary information, including the insurer's benefit determination on review, will be transmitted between the insurer and the *covered individual* by telephone, facsimile, or other available similarly expeditious method.
   c. Reviewer's Requirements: The review will be conducted by a doctor chosen by the insurer, who was not involved in the initial determination.
   d. Resolution Timeframe and Notification of Determination:
      (1) The insurer will orally notify the grievant and the *covered individual,* if they are not the grievant, of the decision within 48 hours, and then will provide written notice of the decision.
      (2) The written notice will include the following:
         (a) A statement of the insurer's understanding of the *grievance*;
         (b) The decision reached by the insurer and the contract basis or medical rationale for the resolution stated in sufficient detail for the grievant and the *covered individual,* if they are not the grievant, to respond further to the insurer's position;
         (c) Reference to the evidence or documentation used as the basis for the resolution;
         (d) Notice of the right to request a second-level review, including how, when, and where to make the request; and
         (e) The department, address, and telephone number of the department handling the *grievance,* through which a qualified representative may be contacted to obtain additional information about the resolution and notice of any rights to further review.
         (f) A statement that the grievant and the *covered individual,* if they are not the grievant, is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the *covered individual*'s claim for benefits;
         (g) A statement that the *covered individual* may have a right to bring a civil action under state or federal law;

(h) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the grievant and the *covered individual*, if they are not the grievant, upon request;
(i) If the *adverse benefit determination* is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the *covered individual*'s medical circumstances, or a statement that such explanation will be provided free of charge upon request;
(j) The date of service;
(k) The health care provider's name;
(l) The claim amount;
(m) The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
(n) The insurer's denial code with corresponding meaning;
(o) A description of any standard used, if any, in denying the claim;
(p) That assistance is available by contacting the specific state's consumer assistance department, if applicable;
(q) A culturally linguistic statement based upon the *covered individual*'s county or state of residence that provides for oral translation of the *adverse benefit determination*, if applicable; and
(r) The identification of medical experts whose advice was obtained on behalf of the insurer, without regard to whether the advice was relied upon in making the *adverse benefit determination*.

C. Appeals
1. Standard Appeal Review
a. Request: If the grievant or the *covered individual*, if they are not the grievant, is not satisfied with the *grievance* decision, an appeal of the *grievance* decision may be submitted orally or in writing, within 60 calendar days from receipt of the *grievance* decision.
b. Acknowledgment: Within **5 business days** after receiving the appeal, the insurer will provide the appellant and the *covered individual*, if they are not the appellant:
(1) The name, address, and telephone number of an individual to contact regarding the appeal; and
(2) The date the appeal was filed.
c. Panel Requirements: A request regarding appropriateness, medical necessity, or experimental or investigational treatment will be reviewed by a panel of one or more qualified individuals appointed by the insurer.
(1) The panel must include one or more individuals who:

(a) Have knowledge of the medical condition, procedure, or treatment at issue;
(b) Are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the health care procedure, treatment or service;
(c) Were not involved in the matter giving rise to the review or in the *grievance* review; and
(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 appeal.

(2) Right to Appear: The grievant and the *covered individual,* if they are not the grievant, will be given the opportunity to appear in person before the panel or if unable to appear in person, otherwise appropriately communicate with the panel. The *covered individual* will be notified not less than 72 hours prior to the meeting of the panel. The *covered individual* may waive the 72 hour notice of the meeting of the panel.

(3) The panel will meet during normal business hours and at a place convenient to the grievant and the *covered individual,* if they are not the grievant, who wishes to appear before or otherwise communicate with the panel.

d. Reviewer Requirements:

(1) All appeals of *grievance*s that are based in whole or in part on a medical judgment, other than those involving appropriateness, medical necessity, or experimental or investigational treatment, will be reviewed in consultation with a health care professional with appropriate expertise in the field, who was not involved in the initial determination or the *grievance* review.

(2) An appeal regarding a rescission action will be reviewed by a panel of individuals who were not involved in the initial determination.

(3) All other appeals will be handled by a person who was not involved in the matter giving rise to the review or in the *grievance* review and who has sufficient experience, knowledge, and training to appropriately resolve the appeal.

e. Resolution Timeframe and Notification of Determination:

(1) For *pre-service claim*s, the appeal will be resolved as quickly as possible, but not more than 15 calendar days after receipt. The appellant and the *covered individual,* if they are not the appellant, will be notified in writing of the resolution of the appeal the earlier of 5 business days after the investigation is complete or 15 calendar days after the appeal is received.

(2) For *post-service claim*s, the appeal will be resolved as quickly as possible, but not more than 30 calendar days after receipt of the appeal. The appellant and the *covered individual,* if they are not the appellant, will be notified in writing of the resolution of the appeal the earlier of 5 business days after the investigation is complete or 30 calendar days after the appeal is received.

(3) The written decision will include the following:
(a) A statement of the insurer's understanding of the appeal;

(b) The decision reached by the insurer and the contract basis or medical rationale for the resolution stated in sufficient detail for the appellant and the *covered individual*, if they are not the appellant, to respond further to the insurer's position;
(c) Reference to the evidence or documentation used as the basis for the resolution;
(d) Notice of the right to further remedies allowed by law;
(e) The department, address, and telephone number through which a qualified representative may be contacted to obtain more information about the decision or the right to an external review;
(f) If the appeal is regarding appropriateness, medical necessity, experimental or investigational treatment, or a *rescission:*
    - Notice of the right to external review by an independent review organization (IRO), including a description of the external review procedure; and
    - A copy of the Indiana Authorization Form which authorizes the insurer to disclose protected health information for the external review.
(g) A statement that the appellant and the *covered individual*, if they are not the appellant, is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the *covered individual*'s claim for benefits;
(h) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the appellant and the *covered individual*, if they are not the appellant, upon request;
(i) If the *adverse benefit determination* is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the *covered individual*'s medical circumstances, or a statement that such explanation will be provided free of charge upon request;
(j) The date of service;
(k) The health care provider's name;
(l) The claim amount;
(m) The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
(n) The insurer's denial code with corresponding meaning;
(o) A description of any standard used, if any, in denying the claim;
(p) That assistance is available by contacting the specific state's consumer assistance department, if applicable;

(q) A culturally linguistic statement based upon the *covered individual*'s county or state of residence that provides for oral translation of the *adverse benefit determination*, if applicable; and

(r) The identification of medical experts whose advice was obtained on behalf of the insurer, without regard to whether the advice was relied upon in making the *adverse benefit determination*.

2. Expedited Appeal Review

a. Request: An expedited appeal of a *grievance* regarding an urgent care claim may be submitted orally or in writing.

b. Transmission of Information: All necessary information, including the insurer's benefit determination on review, will be transmitted between the insurer and the appellant and the *covered individual*, if they are not the appellant, by telephone, facsimile, or other available similarly expeditious method.

c. Reviewer's Requirements: The review will be conducted by a doctor chosen by the insurer, who was not involved in the initial determination. A panel is not applicable to expedited appeals.

d. Resolution Timeframe and Notification of Determination:

(1) The insurer will orally notify the appellant and the *covered individual*, if they are not the appellant, of the decision within 48 hours, and then will provide written notice of the decision.

(2) The written decision will include the following:

(a) A statement of the insurer's understanding of the appeal;

(b) The decision reached by the insurer and the contract basis or medical rationale for the resolution stated in sufficient detail for the appellant and the *covered individual*, if they are not the appellant, to respond further to the insurer's position;

(c) Reference to the evidence or documentation used as the basis for the resolution;

(d) Notice of the right to further remedies allowed by law;

(e) The department, address, and telephone number through which a qualified representative may be contacted to obtain more information about the decision or the right to an external review;

(f) If the appeal is regarding appropriateness, medical necessity, experimental or investigational treatment, or a *rescission:*

- Notice of the right to external review by an independent review organization (IRO), including a description of the external review procedure; and
- A copy of the Indiana Authorization Form which authorizes the insurer to disclose protected health information for the external review.

(g) A statement that the appellant and the *covered individual*, if they are not the appellant, is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the *covered individual*'s claim for benefits;

(h) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the appellant and the *covered individual*, if they are not the appellant, upon request;
(i) If the *adverse benefit determination* is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the *covered individual*'s medical circumstances, or a statement that such explanation will be provided free of charge upon request;
(j) The date of service;
(k) The health care provider's name;
(l) The claim amount;
(m) The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
(n) The insurer's denial code with corresponding meaning;
(o) A description of any standard used, if any, in denying the claim;
(p) That assistance is available by contacting the specific state's consumer assistance department, if applicable;
(q) A culturally linguistic statement based upon the *covered individual*'s county or state of residence that provides for oral translation of the *adverse benefit determination*, if applicable; and
(r) The identification of medical experts whose advice was obtained on behalf of the insurer, without regard to whether the advice was relied upon in making the *adverse benefit determination*.

V. EXTERNAL REVIEW OF *GRIEVANCES*

A. Non-Expedited Request:
1. After exhausting the internal review process, a *covered individual* or a *covered individual*'s representative has 120 days after notice of the appeal decision to request an external review in writing with the insurer. A request for external review may only be made for a *grievance* regarding:
   a. A determination that a service or proposed service is not appropriate or medically necessary;
   b. A determination that a service or proposed service is experimental or investigational; or
   c. The insurer's decision to *rescind* an accident and sickness insurance policy.
2. The *covered individual* who files a request for an external review shall:
   a. Not be subject to retaliation for exercising their right to an external review;
   b. Be permitted to utilize the assistance of other individuals, including health care providers, attorneys, friends, and family members throughout the review process;

c. Be permitted to submit additional information relating to the proposed service throughout the review process; and
d. Shall cooperate with the Independent review organization (IRO) by providing any requested medical information and authorizing the release of necessary medical information.

B. Expedited Request: An expedited request may be made for *grievances* related to an illness, disease, condition, injury, or disability if the time frame for a standard review would seriously jeopardize the *covered individual*'s:
1. Life or health; or
2. Ability to reach and maintain maximum function.

C. Procedure:
1. When a request for external review is filed, the insurer will:
   a. Select an IRO from a list of IROs that are certified by the Department of Insurance (DOI); and
   b. Rotate the choice of an IRO among all certified IROs before repeating a selection.
2. The insurer will cooperate with the IRO by promptly providing the IRO with any information requested by the IRO.
3. If, at any time during an external review, the *covered individual* submits information to the insurer that is relevant to the insurer's resolution and was not previously considered, the insurer may reconsider the previous resolution.
   a. The IRO will cease the external review process until the reconsideration is completed.
   b. The insurer will notify the *covered individual* of the decision within 15 business days after the information is submitted (72 hours for an expedited review).
   c. If the insurer's decision is adverse to the *covered individual*, the *covered individual* may request that the IRO resume the external review.
4. If the insurer chooses not to reconsider, the insurer will forward the submitted information to the IRO within 2 business days after receipt.

D. Resolution Timeframe and Notification of Determination:
1. The IRO will make a determination to uphold or reverse the insurer's determination within 15 business days (72 hours for expedited) after the request for external review is filed. The IRO will base their determination on information gathered from the *covered individual* or the *covered individual*'s designee, the insurer, and the treating health care provider, and any additional information that the IRO considers necessary and appropriate.
2. The IRO will notify the insurer and the *covered individual* of their determination within 72 hours of making the determination (72 hours after the external *grievance* is filed for expedited).

E. General Information:
1. An external review decision is binding on the insurer.
2. The insurer will pay for all costs of the external review by the IRO.
3. A *covered individual* may not file more than one external review request of an insurer's appeal resolution.