SIHO INSURANCE SERVICES

POLICY AND PROCEDURES

AP: 17:01	Appeals Procedures		
Written By:	Gretchen DeBord	**Effective Date:**	11/15/11
Renewed/Revised By:	Gretchen DeBord	**Renewed/Revision Date:**	8/1/17
Approved By:	Dawn Coomer	**Next Review Date:**	8/1/18
Former P&P:	CS 14:03 R3	**Retirement Date:**	N/A

1.0 SCOPE: *Target Group*

Please select:

- Line of Business (*if IUHP or CHS, please also check CAS*)

☒	CAS		☒	SIHOPS/TPA
☐		IUHP	☐	Genesis
☒		CHS	☐	Operations/Administration
☒	SIHO/FI		☐	Other (Specify)

- Department (*Check Department(s) that this policy covers*)

☐	ALL COMPANY	☐	Human Resources
☐	Account Mgmt.	☐	ID Cards
☐	Administration	☐	Information Technology
☒	Appeals	☐	IU Health Employer Services
☐	Business Continuity	☐	Legal
☐	Claims Recovery	☐	Medical Management
☐	Claims Services	☐	Member Services
☐	Client Services Support	☐	Network Services
☐	COBRA	☐	Population Health Mgmt.
☐	Compliance	☐	Product Development
☐	Data Management	☐	Project Management
☐	Data Systems and EDI	☐	Provider Contracting
☐	Document Distribution	☐	Public Relations & Mktg.
☐	Eligibility Services	☐	Quality Improvement
☐	Employer Services	☐	Reinsurance
☐	Facility Management	☐	Rental Networks
☐	Finance	☐	Sales
☐	Flex & HRA	☐	Short Term Disability & Workers Compensation
☐	Fully Insured	☐	Wellness
☐	HIPAA	☐	Other (Specify)

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

3.0 **POLICY:** All appeals will be thoroughly investigated, evaluated and resolved in a timely manner and in compliance with applicable local, state or federal law or relevant accreditation standards. Documentation will be entered into SIHO's internal system.

4.0 **PROCEDURES:**

4.1 All appeal requests will be immediately forwarded to the Appeals Coordinator to be handled through the appeal procedures.

4.1.1 When the appeal is initially received, the Appeals Coordinator will document the appeal in the appropriate electronic Appeals Log found on the Appeals network drive. Throughout the entire appeals process, the Appeals Coordinator will continue to update this log as information is received specific to the appeal.

4.1.2 The Appeals Coordinator will create an electronic file folder for each Appeal received. All documentation, including correspondence, received with the initial appeal will be scanned and saved on the Appeals network drive. All correspondence (both sent and received), review documentation, and final determination related to the appeal will be saved in the electronic folder. This electronic folder will be retained on the Appeals network drive for a minimum period of six (6) years from the date of the last benefit determination.

4.1.3 The Appeals Coordinator will scan all appeals documentation into the HSP claims system. The appeal documentation will be indexed to the claim, for post-service appeals or to the member, for pre-service appeals.

4.2 For all appeal requests (verbal or written), the Appeals Coordinator will enter an Event log in the HSP system documenting the receipt of the appeal.

4.3 For all appeal requests (both member and provider), an acknowledgement notice will be sent to the appealing party and the member within three (3) business days of receipt of the appeal request.

4.4 The Appeals Coordinator will begin investigating the issue and gather the data needed to review the the appeal, including, but not limited to; call history, claims history, referral history, medical records, and benefits outlined in the applicable SPD or Certificate of Coverage.

4.5 The Appeals Coordinator is authorized to overturn any initial determination that involves an error made by SIHO or a SIHO provider and does not involve medical necessity, appropriateness determination, or benefit issues/limitations, up to $1,500.00.

4.6 The Appeals Coordinator will review the documentation submitted and documentation from paragraph 4.4 above to determine the appropriate reviewing party for the Appeal.

4.6.1 If the Appeal is medical in nature, the Appeals Coordinator will forward all documentation related to the appeal to the Medical Management

Department. The Medical Management Department will forward all documentation to the Medical Director for review.

4.6.1.1 If the Medical Director is the same speciality and/or has expertise as the services in question, he/she will review the documentation to determine if the appeal should be upheld or overturned.

4.6.1.2 If the Medical Director is not of the same speciality and does not have the expertise required to perform the review, he/she will indicate so and request that the review be conducted by a physician of the appropriate specialty.

4.6.2 If the Appeal is non-Medical in nature, the Appeals Coordinator will determine if there is an appropriate reviewing party. The appeal documentation will be forwarded to the appropriate reviewing party.

4.6.3 If the Appeals Coordinator determines there is not an appropriate reviewing party, he/she will forward the documentation to the members of the Appeals Committee for review.

4.6.3.1 The Appeals Coordinator will schedule an Appeals Committee meeting so that the appeal can be discuss and voted upon in an open forum.

4.6.3.2 Once the Appeals Committee has reached its decision, the decision will be documented and approved via signature by committee members. The documented decision will be scanned into the HSP claims system and saved in the member's electronic file.

4.6.3.3 The Appeals Committee does not have the authority to overturn a benefit exclusion or plan limitiation.

4.6.4 If the Appeals Coordinator determines the Appeals Committee does not have the authority to make a determination for the appeal, he/she will forward all documentation to the Account Manager, so that the Account Manager can discuss with the group to determine if an exception to benefit should be granted for the services.

4.6.5 The Appeals Coordinator will update the log to indicate the reviewing party and date sent to the reviewing party.

4.6.6 The Appeals Coordinator will follow up with the reviewing party to ensure timely resolution of the appeal.

4.7 The resolution of all appeals will be documented and forwarded to the appropriate department if further action is needed. All final appeal documentation is scanned into the HSP system for future reference. Any improvements to current processes should be discussed with the appropriate departments and corrective action plans implemented.

4.8 All appeals electronic log record will be updated with the resolution of the appeal.

4.9 Per applicable local, state, and federal law and relevant accreditation standards, notification of the resolution of the appeal will be sent to the appellant within 72 hours of the final decision and within thirty (30) calendar days of the receipt of the

appeal request. This notice will include the appellant's right to request an External Review per applicable governmental guidelines for non-grandfathered plans.

4.10 Appeal documentation will be trended by the Appeals Coordinator and reported to the Quality Management Committee as requested.

4.11 The Appeals Coordinator will begin compiling all information on appeals for Fully Insured claims from the previous year on January 15th. This log will be sent to the Vice President and Controller of Finance Department and the Vice President and Director of Fully Insured no later than February 1st. At that time, the Financial Operations Director and Assistant Controller will also receive a copy of this log. The Finance Department will then submit log results to the Indiana Department of Insurance (IDOI) by March 1st.

5.0 CLAIMANTS RIGHTS ON APPEALS

5.1 The appealing party will have the opportunity to submit written comments, documents, or other information relating to the issue.

5.2 Upon request and free of charge, the claimant will be provided with reasonable access to and copies of, all documents, records and other information relevant to the appeal.

5.3 The appeal review will take into account all comments, documents, records and other information the claimant submits, whether or not presented or considered in the initial determination.

5.4 No deference will be afforded to the initial determination.

5.5 The review will be conducted by a person different from the person who made the initial determination and who is not the original decision-makers subordinate.

5.6 If the decision is made on the grounds of a medical judgment, SIHO will consult with a health care professional with appropriate training and experience. The health care professional will not be the individual who was consulted during the initial determination or that person's subordinate.

6.0 DRUG UTILIZATION MANAGEMENT APPEALS

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

business relationship with the covered individual or the health care provider who previously recommended the health care procedure, treatment or service giving rise to the grievance;

6.1.1 If the Associate Medical Director is qualified in accordance with the prior sentence to make the determination, then s/he will do so.

6.1.2 If there are no internal persons so qualified, then the Appeals Coordinator will send all relevant information to a third party who is qualified to determine the appeal.

6.1.3 If the claim was reversed per the review described in this section, enter an Event and route to the appropriate department for the claim to be reprocessed or authorization to be updated. If the decision was made to uphold the denial, enter an Event and a letter sent to the appellant to notify them the claim has been denied and why the decision was made within 72 hours of the decision. Copies of the SPD language showing the reason for the decision should be included.

7.0 EXPEDITED APPEALS

7.1 The appellant may request an expedited appeal either verbally or in writing, or SIHO may independently determine that the process should be expedited due to the medical necessity of the appeal. The expedited process is considered a stand-alone procedure and is in lieu of the standard appeal procedure outlined in section 4.0 of this policy.

7.2 The process to resolve an expedited appeal will be the same as a non-expedited except for the accelerated time frames described in this section.

7.3 Resolution of an expedited appeal will be made as expeditiously as the appellant's health warrants but will occur no later than 72 hours after the filing of the appeal.

7.4 The appellant or their designated representative will be verbally notified within the 72 hours of the expedited appeal determination. Within one (1) business day after the verbal notification, a notice will be sent via mail to the appellant regarding the expedited appeal determination.

8.0 NOTIFICATION OF RESOLUTION OF APPEAL

8.1 Urgent Care Claims: In the case of an appeal involving an urgent care issue, SIHO will notify the claimant of its decision within 72 hours after it received the request for review.

8.2 Pre-Service Claims: In the case of a Pre-Service issue not involving urgent care, SIHO will notify the appealing party of its decision within fifteen (15) days after it receives the request for review.

8.3 Other Claims: In the case of all other issues, SIHO will notify the appealing party within 30 business days after it receives the written request for review.

9.0 NOTICE OF DECISION ON INITIAL APPEAL

9.1 If an initial appeal is denied, SIHO will notify the claimant, in writing or electronically. The notice will contain the following information:

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

10.0 EXTERNAL REVIEW OF APPEALS PROCESS

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

10.2 An appellant may not file more than one (1) External Appeal request on the same appeal.

10.3 Upon receipt of the request for External Appeal review, the Appeals Coordinator will enter an Event into the HSP system. The Appeals Coordinator will select an independent review organization that is certified to perform external reviews under PPACA and URAC regulations, has not been involved in the original determination under appeal, and is listed as approved by the Indiana Department of Insurance at http://www.in.gov/idoi/files/IRO_Rotation_List_website_11-20-13-a-1.doc.doc.

10.4 The appeals should be sent to these organizations in sequential order from the rotation list indicated above. No review organization shall be used again until all other review organizations have been used once. In order to create a consistent process, self-funded appeals will follow the same process as the fully-insured appeals. The pre-determined list of organizations to send external appeals to for

fully-insured and self-funded groups is titled "External Reviewer" and is saved in the Appeals Drive in the External Review folder.

10.5 The external review organization and the medical review professional conducting the external review may not have a material professional, familial, or financial, or other affiliation with SIHO; any officer, director, or management employee of SIHO; the physician or the physician's medical group that is proposing the service; the facility at which the service would be provided; or the development or manufacture of the principal drug, device, procedure, or other therapy that is proposed by the treating physician.

10.6 An appellant who files an appeal under this final alternative is not subject to retaliation for exercising their right to an appeal by an external review organization. An appellant may be permitted to utilize the assistance of other individuals, including physicians, attorneys, friends, and family members throughout the external review process. An appellant shall be permitted to submit additional information relating to the proposed service throughout the review process and may cooperate with the external review organization by providing any requested medical information or authorizing the release of necessary medical information.

10.7 SIHO shall cooperate with the external review organization by promptly providing any information requested by the external review organization.

10.8 The external review organization shall make a determination to uphold or reverse SIHO's appeal resolution based on information gathered from the appellant, SIHO, the treating physician, or any additional information that the external review organization considers necessary and appropriate. For standard appeals, the determination shall be made within 15 business days from the filing date of the request for external review. For expedited appeals, the determination and notification to the appellant shall be made within 72 hours after the external review request is filed. **The result of the determination is binding on SIHO.**

10.9 When making the determination of the resolution of the appeal, the external review organization shall apply the standards of decision making that are based on objective clinical evidence and the terms of the appellant's benefit contract.

10.10 If at any time during the external review process the appellant submits information to SIHO that is relevant to SIHO's previous appeal resolution and was not considered by SIHO during the appeals phase, SIHO shall reconsider the previous resolution under the appeals hearing process. The external review organization shall cease the external review process until the reconsideration by SIHO is completed.

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

11.0 BUSINESS CONTINUITY PROCEDURES:

11.1 If this procedure is potentially impacted by a business interruption greater than four hours, is an emergency plan required? N/A

12.0 DEFINITIONS

12.1 Appeal: an oral or written request from a member or provider to change a previous decision made by SIHO that was unresolved to the member or provider's satisfaction at the first appeal.

12.2 Expedited appeal: an appeal that is completed within 72 hours of the request and followed by a written confirmation of the notification.

12.3 External appeal: an appeal that is sent to an independent reviewer after all internal appeal mechanisms have been exhausted, for clinical determinations relating to the necessity or appropriateness of medical servies.

12.4 Drug Utilization Management Appeal: an appeal based on a process of appraising and reconsidering the usage of drugs to determine the effectiveness of drug treatment.

13.0 LEGAL/REGULATORY REFERENCES:

13.1 IN Code: IC 27-8-28 (Internal Appeals) and IC 27-8-29 (External Appeals)

13.2 URAC HUM Standards Version 7.0

13.3 PPACA Legislation

13.4 NCQA Policies for Appeals

14.0 ATTACHMENTS:

14.1 N/A

Approved By Signature	/s/ Dawn Coomer, Manager	**Date**	8/1/17