POLICY AND PROCEDURE

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Appeal of Adverse UM and Benefit Determinations
PAGE: 1 of 13	**REPLACES DOCUMENT:**
APPROVED DATE:	**RETIRED:**
EFFECTIVE DATE: 01/2014	**REVIEWED/REVISED:** 12/2014; 9/2015; 09/2016; 11/2016; 12/2016; 01/2017; 09/2017; 09/2018; 06/2019; 01/2020
PRODUCT TYPE: Marketplace	**REFERENCE NUMBER:** HIM.UM.08

SCOPE:
Corporate and Marketplace Health Plan Medical Management Departments

PURPOSE:
To offer a full and fair process for resolving members' disputes and responding to members' requests to reconsider a decision they find unacceptable regarding their care and service. This policy applies to all Marketplace Plans; any state regulations more stringent than the documented process and variations to the procedure are maintained in Marketplace State Regulation Grid. Supplemental state addendums are attachments providing state specific information and regulations that impact compliance.

POLICY:
It is the policy of Marketplace that a member, legal representative(s) of a deceased member's estate, or an authorized representative of a member acting on their behalf (with written consent from the member) may appeal an adverse determination regarding their care and service. A health care practitioner with knowledge of the member's medical condition, acting on behalf of the member (with written consent from the member as dictated by state contract, as applicable), may also file an appeal. Punitive action will not be taken against a provider who requests an expedited resolution or supports a member's appeal.

Members will be provided a reasonable timeframe to file an appeal, i.e. no longer than 180 calendar days from the date of the Marketplace Plan's notification of adverse determination or within the timeframes as designated by the state Department of Insurance, if more stringent.

The Marketplace Plans will review, resolve and provide the member with written or electronic notification of the appeal decision as quickly as the member's health condition requires but no later than:

- **Pre-service appeals** - 30 calendar days (or per state timeframes if more stringent)
- **Post-service appeals** - 60 calendar days (or per state timeframes if more stringent)
- **Expedited appeals** - 72 hours (or per state timeframes if more stringent)

The timeframe for disposition of standard and expedited appeals may be extended for up to 14 calendar days if the member, the member's authorized representative, or

health care practitioner acting on behalf of the member requests the extension or voluntarily agrees to the extension. For any extension not requested by the member, Marketplace Plans will give the member written notice of the reason for the delay and obtain the member's consent for the extension. If the member does not consent to the extension, the appeal will be decided with the information available before the timeframe expires. An appeal may be withdrawn by written request from the person who filed the appeal.

Continued coverage pending the outcome of the appeal of concurrent care decision will be allowed until the end of the approved treatment period **or** determination of the appeal (subject to regulatory and contractual obligations). Continued coverage pending outcome of the appeal only applies to denial, reduction, or termination of coverage for an ongoing course of treatment for which coverage was previously approved. It does **not** apply to requests for extensions.

Members that express language barriers and or special needs can obtain assistance using the Plans Language Line/TDD to file their appeal. If the member files their appeal using the interpreter or TDD service, then the Plan notifies the member of the resolution of their appeal using that same resource. All appeal notices will be based on members' cultural and linguistic needs, as applicable.

PROCEDURE:

I. Filing an Appeal

- **A.** An appeal may be filed orally or in writing, and received via mail, telephone, facsimile, electronic mail, or in person. Members must confirm an oral appeal request in writing (other than for an expedited request). Members must file an appeal request within 180 calendar days of the Marketplace Plan's notice of adverse action to the member, or per timeframes dictated by state regulation, if more stringent.
- **B.** The Plan will assist any member requesting assistance in understanding an adverse determination notice and in filing an appeal, including any member with special communication needs.
- **C.** Members appealing urgent care services may request an expedited appeal. An expedited appeal review may be requested orally by the member, the member's authorized representative, or a health care practitioner acting on the member's behalf and begins upon such request. A practitioner with knowledge of the member's condition may request an expedited appeal on a member's behalf;

written member consent is not required for expedited appeals requested by the provider.

An expedited appeal request must be granted to all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from the facility. The Plan must provide an expedited appeal if a physician demonstrates that the standard timeframe for an appeal decision could seriously jeopardize the life or health of the member or the member's ability to regain maximum function. Expedited appeals are not available for post-service requests.

If the Plan denies a request for an expedited appeal, the appeal must automatically be transferred to the standard timeframe. For Marketplace plan members, a reasonable attempt must be made to provide oral notification of the expedited request denial and followed up with written notice within 2 calendar days (CFR 438.410).

II. Acknowledging an Appeal

A. The member appeal is acknowledged in writing within 5 business days of the receipt of a request for an appeal. The acknowledgement letter includes notification of member rights and appeal processes in a culturally and linguistically appropriate manner:

- The date the appeal was received.
- The member's right to choose additional representation by anyone, including an attorney, physician, advocate, friend or family member to represent him or her during the appeal process. The designation of their authorized representative must be submitted to the Plan in writing.
- The member's right to submit comments, documents or other information relevant to the appeal. In the case of expedited appeal requests, the member will be informed of the limited time available to provide the information.
- The member's right to present information relevant to the appeal within a reasonable distance so that the member can appear in person if desired.
- The timeframe for resolution of the appeal and further appeal rights, if any.
- For the Plans that are required to offer a Grievance Panel, the member acknowledgement letter will include the right and the information for member to request the Panel. Should the member request the Panel for the grievance or appeal, the Coordinator will facilitate a panel that

includes an insured other than the grievant, the Plan Medical Director, not involved in the prior decision, who is authorized to take corrective action and one additional Plan staff member.

III. Investigating an Appeal

A. The Plan will fully investigate and document the content of the appeal including all aspects of clinical care involved, without giving deference to the denial decision. All information will be taken into account regardless of whether the information was submitted or considered in the initial determination.

B. The appeal will be reviewed by a person or people who were not involved in the prior adverse decision. The appointed person will neither be the individual who made the adverse determination nor a subordinate of such individual; however, the practitioner who made the initial adverse determination may review the case and overturn the previous decision.

C. Appeals with regard to whether a particular treatment, drug or other item is experimental, investigational or not medical necessity or appropriate will be reviewed by a clinical peer who holds an active, unrestricted license to practice medicine or a health profession, who is board-certified if applicable, and who is of the same-or-similar health care professional and has similar credentials and licensure and appropriate training and experience as those who typically treat the condition or health problem in question in the appeal.

IV. Resolving an Appeal Not Related to Formulary

A. The Plan must resolve a **pre-service appeal** and provide the member with written or electronic notification of the decision within 30 calendar days of the pre-service appeal request (or per state regulation timeframes, if more stringent).

B. **Post-service appeal** resolution and notification must be made in writing or electronically within 60 calendar days of receipt of the appeal request (or per state regulation timeframes, if more stringent).

C. Decisions regarding **expedited appeals** will be made as expeditiously as the member's health condition requires, but no later than 72 hours (or per state regulation timeframes, if more stringent) after the appeal request is made.

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D. Marketplace Plans may extend the resolution notification time frame, for standard appeals, for up to 14 calendar days to obtain additional information only if:

- The member requests an extension or

- The member voluntarily agrees to extend the appeal time frame.

Written notification of the reason for the delay is provided to the member, if the member has not requested the extension, and the member's consent for the extension is obtained. If the member does not consent to the extension, the appeal will be decided with the information available before the timeframe expires.

F. If the Plan fails to meet the above resolution timeframes, the member may submit their appeal for an external independent review.

G. The Plan will send the appellant a written notification of the resolution determination of the appeal. When the adverse decision is upheld in whole or part, the written appeal decision notification must include the following elements, when applicable:

- Date of the appeal resolution;
- Specific reasons for the appeal decision, in easily understood language. The reason for the decision will be provided in plain language that a layperson would understand and does not include abbreviations or acronyms that are not defined in the notice, or procedure codes that are not explained.
- A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.
- Notification that the member can obtain a copy free of charge, upon request, of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based with any new or additional evidence.
- Notification that the member is entitled to receive, upon request and at no additional cost, reasonable access to and copies of all documents relevant to the appeal including any new or additional evidence. Relevant documents include documents and records relied upon in making the appeal decision and documents and records submitted in the course of making the appeal decision.
- A list of titles and qualifications, including specialty of the individual conducting the medical necessity review, of individuals participating in the appeal review. (Participant names do not need to be included in the written notification to members, but must be provided to members upon request). For benefit appeals, the reviewer' title at minimum must be provided.
- A description of the next level of appeal, with an Independent Review Organization (IRO), as applicable and described further in section VI

below, along with any relevant written procedures and contact information (appeal rights are required whenever the organization makes a decision that is adverse to the member).

- Notification is given to the member and the provider/facility.

H. For **expedited** appeals, initial notification of the appeal decision may be provided orally to the party requesting the appeal and must be provided within 72 hours of receipt of the appeal request (or per state timeframes if more stringent). If initial notification is oral, written notification must be sent to the member and provider/facility no later than 3 calendar days after the initial oral notification, or per state contract requirements if more stringent. The Plan may inform the hospital UR department staff of the appeal decision, with the understanding that UR staff will informed the attending/treating practitioner.

I. If the Marketplace Plan completely overturns the denial, the appeal notice must state the decision and the date. The Plan will authorize or provide the disputed services promptly and pay for the disputed services if the member received the services while the appeal was pending.

V. Resolving an Appeal Related to Formulary

A. The Plan must have a process for an enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber) to request an expedited review (24 hours) or standard review (72 hours) of a decision that a drug is not covered by the Plan.

B. If the Plan denies a request for a standard exception or for an expedited exception, the Plan must have a process for the enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber) ***to request*** that the original exception request and subsequent denial of such request be reviewed by an independent review organization.

VI. External Independent Review

Marketplace members have the right to the following external appeal processes and must be communicated in the appeal resolution letter:

A. A member, their legal representative, or provider (with the member or legal guardian's written consent), may request an external third-party binding review by an IRO after the Plan's internal grievance/appeal process has been exhausted, as applicable, and defined by the state regulations for all medical necessity denials. The request may be concurrent in the case of expedited appeals.

B. The parties to an IRO include Plan, as well as the member, his/her legal representative or the representative of a deceased member's estate.
C. The request for an IRO must be submitted within one hundred twenty (120) calendar days from the date of the notice of action regarding their expedited or standard appeal (or per state timeframes if more stringent). The Plan will assist the member or their representative with filing the appeal, as requested.
D. The member shall not be required to bear the costs of the IRO, including filling fees.
E. The Plan shall have no material professional, familial or financial conflicts of interest with the IRO.
F. The Plan will not attempt to interfere with the IRO's proceedings or appeal decision.
G. The Plan will conduct a preliminary review within five (5) business days (immediately for expedited) to provide the IRO, or Department of Insurance as required, with information regarding the eligibility of the member, whether the requested services are a covered benefit, the status of the internal appeal, and any necessary forms required. The plan will alert the member, IRO if already assigned, or state regulatory entity as required, if there are any identified issues with the request for external review.
H. The member will be notified in writing within one (1) business day of the preliminary review whether the request is complete but not eligible for external review and the reasons for its ineligibility or , if the request is not complete, the additional information needed to make the request complete. The Plan will allow the member to correct the filing within the filing timeframe or within 48 hours of the notification.
I. The Plan, on a rotating basis of contracted IROs, or the state regulatory agency as applicable, will select the IRO to complete the review.
J. The Plan will cooperate with the IRO in the hearing process and submit a copy of the member's internal appeal of the Plan's action; the contents of the internal appeal file including research, medical records and other documents used to make their decision and a summary of the member's appeal; the evidence used by the Plan to make its decision; and a copy of the notice of resolution provided to the member and to the IRO within 5 business days of the notice or the required timeframe noted in Appendix A if more stringent.
K. The IRO will conduct a thorough review in which it considers all previously determined facts, allows the introduction of new information, considers and assesses sound medical evidence and makes a decision that is not bound by the decisions or conclusions of the internal appeal.

L. The IRO decision will be made within the parameters set by the state or if the state does not set a standard, within 45 calendar days of the request.
M. The Plan will maintain or obtain data from the IRO on each appeal case and use this information in evaluating its medical necessity decision-making process.
N. The member will be notified of the IRO decision, including the time and procedure for claim payment or approval of service, in the event the IRO overturns the organization's decision.
O. The Plan will implement the IRO's decision within the time frame specified by the IRO.
P. The member will be notified, in writing or electronically, annually and with each eligible appeal of the right to request an external independent review and the contact information of the Independent Review Organization.

VII. Documentation and File Requirements

All appeals requests will be documented and kept on file in a centralized location for a period of no less than ten (10) years. Appeal files will contain at a minimum:

- Documentation of the substance of the appeal and actions taken, including name of the member and associated provider and/or facility. Documentation includes the member's reason for appealing the denial and any additional clinical or other information included with the appeal request.
- Investigation of the appeal, including any aspect of clinical care involved.
- As applicable, if members do not submit information relevant to the appeal in the specified timeframe.
- All actions taken related to the appeal, including previous denial or appeal history and any follow-up activities associated with the original denial and conducted prior to the current appeal being received.
- Date of appeal reviews and the name and credentials of the reviewer(s) who made the appeal decision.
- Notifications, include documentation of verbal and written notifications of acknowledgement, resolution, etc. of the appeal.
- All other correspondence and records associated with the appeal.
- Minutes or transcripts of appeal proceedings, if any.

VIII. Summaries of appeal actions, trends, and root causes are reported at least annually to the Quality Improvement Committee and are reviewed to look for opportunities to improve quality of care and/or service.

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EFFECTIVE DATE: 01/2014	**REVIEWED/REVISED:** 12/2014; 9/2015; 09/2016; 11/2016; 12/2016; 01/2017; 09/2017; 09/2018; 06/2019; 01/2020
PRODUCT TYPE: Marketplace	**REFERENCE NUMBER:** HIM.UM.08

REFERENCES:
NCQA Current Health Plan Standards and Guidelines
Code of Federal Regulations: 42 CFR 438
Code of Federal Regulations: 156.122(c)

ATTACHMENTS:
Marketplace State Regulation Grid
AR Addendum
OH Addendum
MS Addendum
NH Addendum
TX Addendum
WA Addendum
IN Addendum
IL Addendum
TN Addendum

DEFINITIONS:
Action/Adverse Determination: the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension or termination of a previously authorized service; the denial, in whole or part of payment for a service; the failure to provide services in a timely manner; or the failure to act within the time frames specified for making or notifying the member of such action.
Appeal: request for a Plan to reconsider a previous decision regarding an adverse determination. A member or authorized representative of a member may appeal any adverse decision. There may be several levels of appeal and the appeal process may be conducted internally or externally or both as required by State/Federal regulations.
Expedited appeal: a request to change an adverse determination regarding urgent care as defined below. Additionally, requests for an expedited appeal review must be granted to any request concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility.
External appeal: a request for an independent, external review of the final

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adverse determination made by the Plan through its internal appeal process. This may include, but is not limited to, Independent Review Entity, Administrative Law Judge, Medicare Appeals Council, Quality Improvement Organization, or State Fair Hearing.

Post-service appeal: a request to change an adverse determination for care or services that have already been received by the member; regarding a request for reimbursement of services received.

Pre-service appeal: regarding a request for provision of service; a request to change an adverse determination for care or service that the Plan must approve, in whole or in part, in advance of the member obtaining care or services.

Same-or-similar specialist: practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal or who has experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems.

Urgent care: any request for medical care or treatment, with respect to which the application of the time period for making non-urgent care determinations, could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on the prudent layperson's judgment or, in the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

REVISION LOG:	**DATE**
Added 48 hour timeframe to extension of expedited appeal; and updated the State regulation grid with 2015 Plan information.	11/2014
Policy Addendums created to identify process differences between health plans. Updated record retention to match Corporate Standard 10 years.	9/2015
NH Addendum added	12/2015
Annual review: Updated approver titles; updated attachment "IN Addendum- Appeal of Adverse Determinations"; Added the following verbiage: **VI. Resolving an Appeal related to formulary** **A.** The health plan must have a process for an enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber) to request an expedited review (24 hours) or standard review (72 hours) of a decision that a	09/09/16

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APPROVED DATE:	**RETIRED:**
EFFECTIVE DATE: 01/2014	**REVIEWED/REVISED:** 12/2014; 9/2015; 09/2016; 11/2016; 12/2016; 01/2017; 09/2017; 09/2018; 06/2019; 01/2020
PRODUCT TYPE: Marketplace	**REFERENCE NUMBER:** HIM.UM.08

drug is not covered by the plan.

B. If the health plan denies a request for a standard exception or for an expedited exception, the health plan must have a process for the enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber) ***to request*** that the original exception request and subsequent denial of such request be reviewed by an independent review organization.

Deleted the following verbiage:

III. Continuation of Benefits during Appeal Process

A. In accordance with CFR 438.420, the Plan will continue the member's benefits (as applicable) throughout the appeal process and until issuance of the final appeal decision if all of the following occurs:

- The member of their authorized representative file an appeal on or before the latter of the following:
  - Ten (10) days from the *Notice of Action*; or
  - The intended effective date of the Plan's action
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The period covered by the original authorization has not expired; and
- The member requests a continuation of benefits

B. If the Plan continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

- The member withdraws the appeal
- The member does not request an External Independent Review within ten days of receiving an *Appeal Final* adverse decision.
- A department hearing decision adverse to the member is made; or
- The authorization expires or authorization service

limits are met.	
Updated TX Addendum "Appeal of Adverse Determinations" for current practice. Updated NH, MA, and WA Addendums and Marketplace State Regulation Grid to reflect current practice. Formatting changes; moved verbiage to different sections and removed duplicative language; added detail to documentation section.	11/2016
Added IL Addendum	12/2016
Updated WA Addendum	01/2017
Annual review; no significant changes noted	09/2017
Added TN Addendum	06/2019
Minor verbiage changes; Policy name change	02/2020

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Archer, Centene's P&P management software, is considered equivalent to a physical signature.

Director, Medical Management: Approval on File
Sr. Manager, Medical Management: Approval on File

POLICY AND PROCEDURE

DEPARTMENT: Compliance	**DOCUMENT NAME:** HIM Grievance System
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APPROVED DATE: 07/26/18	**RETIRED DATE:**
EFFECTIVE DATE: 07/26/18	**REVIEWED/REVISED DATE:** 3/19, 5/19, 9/19, 3/20, 5/20
PRODUCT TYPE: Marketplace	**REFERENCE NUMBER:** HIM.IN.A&G.01

SCOPE:
This policy applies to Managed Health Services (MHS) Compliance, Quality Improvement, and Member Service Departments. This policy and procedure applies to the Marketplace line of business.

PURPOSE:
To offer a thorough and consistent process for members to express dissatisfaction to the health plan. The process will include acknowledgement, tracking, investigation and timely resolution as well as the opportunity for the member to appeal the resolution if they are not satisfied with the MHS response.

POLICY:
MHS will establish and maintain a procedure for the receipt and prompt internal resolution of all complaints and grievances that complies with all applicable state and federal laws.

Members or their authorized representative may file a grievance orally, or in writing. A health care practitioner or provider acting on behalf of the member may file a grievance.

Grievances
A *grievance* is defined, in accordance with IC 27-8-28-6, Sec. 6., as any dissatisfaction expressed by or on behalf of a covered individual regarding:

- a determination that a service or proposed service is not appropriate or medically necessary;
- a determination that a service or proposed service is experimental or investigational;
- the availability of participating providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between:
    - a covered individual and an insurer; or
    - a group policyholder and an insurer; or
- an insurer's decision to rescind an accident and sickness insurance policy; 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.

Any other matters that pertain to the delivery of health care, such as dissatisfaction with the quality of care or services received, provider, provider staff, or health plan staff conduct (such as rudeness) or the failure to respect an enrollee's rights should be considered a grievance regardless of the timeframe for resolution, per the terms of regulations at Title 42 CFR 438, Subpart F.

> If the matter requires MHS to review the situation and supply a decision, the grievance will include appeal rights if the subsequent decision is an adverse determination. ***For appeals related to denial of medical necessity or benefit limitations please refer to policy HIM.UM.08 – Appeal of UM Decisions Policy.***

MHS will not take action against a member or provider solely on the basis that a grievance or appeal was filed.

PROCEDURE:

A. Member Notification of Grievance Process

1. Members are notified of the MHS Grievance Process in the Member Handbook, on the Ambetter MHS Member Web-Site, at least annually in the Member Newsletter and in any notice of action to members. The notification includes the toll-free number and address at which a grievance or appeal of a grievance may be filed.
2. Ambetter MHS requires its Provider Network to post a description of the Members rights to file a grievance. The posting must be in a conspicuous public location in each facility that offers services on behalf of MHS.

B. Grievance Filing Timeframes

Grievance Step	Filing Timeframe
Step 1 - Grievance (dissatisfaction)	180 calendar days from the date of the event
Step 2 - Appeal of a Grievance	60 calendar days from receipt of the original determination (includes expedited)

For complaints unable to be resolved during the grievance and appeal of a grievance process, members may seek assistance from the governmental agency that regulates insurance at the following:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, IN 46204
Consumer Hotline: (800) 622-4461; (317) 232-2385
Complaints can be filed electronically at www.in.gov/idoi.

C. Filing a Grievance

1. The member, member's authorized representative, or provider, may file a grievance orally or in writing. A grievance will be acknowledged in writing within 3 (three) business days of receipt of the grievance.
2. The Plan gives members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services/bilingual staff, and toll-free numbers that have adequate TTY/TTD and interpreter capability. Refer to IN.MBRS.12.
3. An oral grievance is generally received by a Member Service Representative (MSR) by telephone within 180 calendar days of the situation the member is dissatisfied with. All inquiries received by MSRs are probed to validate the possibility of any inquiry actually being a grievance or appeal.
4. The MSR opens a case in the customer interaction documentation system and documents the substance of the complaint (expression of dissatisfaction received by a member that will be resolved by the close of the next business day from receipt) as provided by the member or the member's authorized representative.
5. The MSR may attempt to resolve the complaint at the time of the call and/or transfer the call. If the MSR resolves the complaint during the call (first call resolution), the case is resolved and marked as complete in customer interaction documentation system. No acknowledgement letter is required.
6. If the complaint is not resolved during the call, the MSR documents the substance of the grievance and any actions taken in the customer interaction documentation system and routes the grievance to the Grievance & Appeals Department.

7. Acknowledgement of an oral grievance, not resolved during the call, is sent in writing by the responsible Grievance Coordinator (GC) within 3 (three) business days of receipt of the grievance.
    a. Written correspondence regarding grievances are received in the mailroom, date stamped and forwarded to the Grievance & Appeals Department the same business day.
8. The GC documents the receipt and a description of the grievance and the date of acknowledgement in the tracking system.
    a. A record of each grievance received will be maintained in accordance with 760 IAC 1-59-5 on the Grievance Tracker Database and within the customer interaction documentation system.
    b. Will be aggregated into the following categories in accordance with NCQA Standards:
        i. Quality of Care
        ii. Access
        iii. Attitude and Service (includes Delegated Vendor Service)
        iv. Billing and Financial Issues
        v. Quality of Practitioner Office Sites

D. Investigation/Research

1. The GC will research and gather supporting documentation regarding the grievance. This may include contacting the member for additional information, requesting information from the provider office, researching the member's claims history or reviewing the member's care plan activity.
    a. **Crisis Calls - Reference policy IN.MBRS.10** for crisis call handling. GC will retain the most updated version of the Crisis Calls process and policy.
2. The GC may send the grievance to another department such as but not limited to Provider Relations or the Billing & Enrollment team for further investigation as appropriate.
3. If the GC receives a grievance that could be a quality of care issue, the grievance case is routed to the QI Coordinator for investigation. Reference policy CC.QI.17.

E. Resolution Time Frames

Grievance Step	Resolution Timeframe
Step 1 - Grievance	Not to exceed 20 business days, from receipt of the request (*An additional 10 business days can be requested if needed*)
Expedited Grievances ***(Clinically urgent grievances)***	48 hours of receipt of the request
Step 2 – Appeal of a Grievance (***Excluding medical necessity decisions***)	30 calendar days from receipt of the appeal request (*An additional 10 business days may be requested if needed*)

F. Resolution of Grievance *(EXCLUDES MEDICAL NECESSITY DECISIONS)*

1. Grievances, *unrelated to medical necessity decisions and benefit limitations*, received at MHS are investigated and resolved by the GC. Applicable grievances related to Quality of Care or Quality Physician Office Sites are routed to the Quality Improvement department for investigation. Refer to policy CC.QI.17 Quality Issues Review.
2. Grievances will be resolved as expeditiously as possible but not more than 20 business days from the date of receipt of the request.
    a. MHS may extend the timeframe for disposition of a standard grievance for up to *10 business days* if the member requests the extension or the Plan demonstrates that there is need for additional information and how the delay is in the member's interest. If MHS extends the timeframe, it shall, for any extension not requested by the member, give the member written notice of the reason for the delay.
    b. The time period may be extended for an additional 10 business days if *we* provide the members and the member's authorized representative, if applicable, written notification of the following within the first 20 business days:
        i. That *we* have not resolved the *grievance*;
        ii. When *our* resolution of the *grievance* may be expected;

iii. The reason why the additional time is needed.

c. The decision regarding the grievance will then be made within 10 business days after the date of the 20 business day time frame expiration.

3. The substance of the grievance, any actions taken, and the resolution will be documented in customer interaction documentation system.
4. Expedited grievances must be resolved as expeditiously as possible not to exceed 48 hours from receipt of the request.
    a. Due to the 48-hour resolution timeframe, the standard requirements for notification and acknowledgement do not apply to expedited grievances, however, MHS will make a reasonable effort to notify the member orally to acknowledge receipt of the expedited grievance.
    b. If the request for an expedited grievance is denied by MHS because it does not meet the criteria for an expedited review, MHS will transfer the grievance to the standard grievance timeframe, make a reasonable effort to notify the member orally of the denial for an expedited review and follow-up with written notice of such within (2) calendar days.
5. The member will be notified in writing of the disposition of the grievance or expedited grievance within (5) business days of the resolution determination date.
    a. MHS will make a reasonable effort to provide oral notification to the member of the resolution of an expedited grievance followed by written notice.
    b. The notice will include the resolution of the issue (to the extent that it can be shared), the member's right to appeal the grievance resolution and instructions on how to make that appeal.
    c. In some instances, MHS may not be able to inform members of the final disposition. In these cases and in all cases related to quality of care, MHS will, at a minimum, send notification that the complaint was received and investigated. The letter will acknowledge receipt of the concern and indicate that the concern was forwarded to the Quality Improvement department for full investigation and corrective action as indicated and that the incident will be tracked for future occurrence.

G. Filing an Appeal of a Grievance

1. If a member is not satisfied with the outcome of the grievance, the member or their authorized representative can file an Appeal to the

decision of the Grievance within 60 calendar days from receipt of the original determination (includes expedited). The instructions and address to submit the appeal is communicated in the closure letter.

2. Assistance with the filing process is available and includes form completion, interpreter services, and toll free phone numbers with TTY/TTD capacity. Reference policy IN.MBRS.12
3. Upon receipt of an appeal of a grievance, the MHS Member Services Representative will review the substance to clearly identify the nature of the concern and the action requested by the member.
4. The responsible Member Service Representative will thoroughly research and document the information related to the appeal to facilitate resolution including but not limited to the previous grievance history of information.
5. The Member Services Representative will open an appeal of a grievance case; document the substance of the grievance and any actions taken in the customer interaction documentation system and route to the Grievance & Appeals Department.
6. The responsible Grievance Coordinator (GC) will send written acknowledgement of the appeal within three (3) business days.
    i. A record of each grievance received will be maintained in accordance with 760 IAC 1-59-5.
    ii. The record will be aggregated into the following categories in accordance with NCQA Standards:
        a. Quality of Care
        b. Access
        c. Attitude and Service (includes Delegated Vendor Service)
        d. Billing and Financial Issues
        e. Quality of Practitioner Office Sites

H. Investigation/Research of the Appeal of a Grievance

1. The GC will research and gather supporting documentation regarding the appeal. This may include contacting the member for additional information, requesting information from the provider office, researching the member's claims history or reviewing the member's care plan activity.
    a. **Crisis Calls - Reference policy IN.MBRS.10** for crisis call handling. GC will retain the most updated version of the Crisis Calls process and policy.

2. The GC may send the appealed grievance to another department such as but not limited to Provider Relations or the Billing & Enrollment team for further investigation as appropriate.
3. If the GC receives an appeal of a grievance that could be a quality of care issue, the case is routed to the QI Coordinator for investigation. Reference policy CC.QI.17.

I. Resolution of Appeal of a Grievance ***(EXCLUDES MEDICAL NECESSITY DECISIONS)***

1. An appeal of a Grievance must be resolved within 30 calendar days of receipt of the request.
2. If MHS is unable to resolve the appeal within 30 calendar days because of circumstances beyond its control, the member is notified in writing that it requires more time to complete the process on or before the end of the 30 calendar day time frame.
    a. The notification for extension must include an explanation of the reason for the delay. MHS must then make a decision regarding the appeal within (10) business days after the date of the 30 calendar day time frame expiration.
    b. The member will be notified in writing of the reason for the delay within the 30 calendar day period with the member's right to file a grievance within 2 days if the member disagrees with the extension.
3. The member will be notified in writing of the disposition of the appeal of a grievance within (5) business days of the resolution determination date.
    a. The written resolution letter will include the decision reached, the reasons, policies and procedures that are the basis of the decision, notice of the member's right to further remedies allowed by law and the department, address and telephone number through which the member may contact a qualified representative to obtain more information.
4. If a member is not satisfied with the outcome of the Appeal of the Grievance, or have a complaint that they have been unable to resolve with MHS, they have the option of seeking the assistance of the Indiana Department of Insurance (IDOI) by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Department
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

POLICY AND PROCEDURE

DEPARTMENT: Compliance	**DOCUMENT NAME:** HIM Grievance System
PAGE 9 of 12	**REPLACES DOCUMENT:**
APPROVED DATE: 07/26/18	**RETIRED DATE:**
EFFECTIVE DATE: 07/26/18	**REVIEWED/REVISED DATE:** 3/19, 5/19, 9/19, 3/20, 5/20
PRODUCT TYPE: Marketplace	**REFERENCE NUMBER:** HIM.IN.A&G.01

Consumer Hotline: (800) 622-4461; (317) 232-2395
Complaints can be filed electronically at www.in.gov/idoi.

REFERENCES:
IC 27-8-28-6 "Grievance"
760 IAC 1-59-14
HIM.UM.08 Appeal of UM Decisions Policy
CC.QI.17 Quality Issues Review
IN.MBRS.08 Member Inquiry Policy
IN.MBRS.10 Crisis Calls
IN.MBRS.12 Hearing Impaired-Interpreter Services

ATTACHMENTS:

DEFINITIONS:
Complaint: A complaint is defines as any expression of dissatisfaction expressed to the insurer by the claimant, or a claimant's authorized representative, about an insurer or its providers with whom the insurer has a direct or indirect contract.
Grievance: A grievance is defined as an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights. The term is also used to refer to the overall system that includes grievances and appeals handled at the Plan level.
Appeal: A request for a Plan to reconsider a previous decision including an action
Action: The denial or limited authorization of a requested service, including the type or level of service;
the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure of the health plan to provide services in a timely manner as defined in the appointment standards described herein; or the failure of the health plan to act within timeframes for the health plan's prior authorization review process specified herein.

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REVISION LOG

REVISION:	DATE:
Section B. Grievance Filing Timeframes "updated Appeal of a Grievance filing timeframe from 180 to 60 calendar days Made grammatical corrections throughout policy Section C. Filing a Grievance, added the definition of a complaint Changed "grievance" to "complaint" where applicable in section C. Section C.#8.b; iii. Added "includes Delegated Vendor Service)" Updated 20 business days to 30 calendar days for Resolution timeframe for Appeal of a Grievance and throughout policy where applicable Added Section G. Filing an Appeal of a Grievance with steps that outline process Added Section H. Investigation/Research of the Appeal of a Grievance with steps that outline process Added to Section I.#2.b. "the member will be notified of the reason for the delay" Added to Section I.#4 the next level of Appeal after the decisions of the Appeal of a Grievance	3/2019
Corrected grammatical errors throughout the policy Added "from the matter that is the subject of the grievance" to section C. Filing a Grievance #1 Added the definition of complaints "expression of dissatisfaction received by a member that will be resolved by the close of the next business day from receipt" section C. Filing a Grievance #3 Added "includes Delegated Vendor Service" to section C. Filing a Grievance #7 iii. Attitude and Service Added section G. Filing an Appeal of a Grievance #1-#6 outlining the steps to file an Appeal of a Grievance Added section H. Investigation/Research of the Appeal of a Grievance #1-#3 Added #4 "if a member is not satisfied with the outcome of the Appeal of the Grievance they have the option to file a	5/2019

State Fair Hearing and included the address, phone, fax info	
Updated Section C. Filing a Grievance; moved #1 to #6 to improve the flow of the process from a complaint to a grievance. Added the steps to resolve a QOC grievance and the steps to process clinically involved grievances. Added to Section B. Filing Timeframes, "If members are not satisfied with the outcome of their grievance and/or appeal of a grievance, the member may seek assistance from the governmental agency that regulates insurance at the following: State of Indiana Department of Insurance Consumer Services Division 311 West Washington Street, Suite 300 Indianapolis, IN 46204 Consumer Hotline: (800) 622-4461; (317) 232-2385 Complaints can be filed electronically at www.in.gov/idoi." Updated Section C; moved #1 to #6 to improve the flow of the process from a complaint to a grievance. Added the steps to resolve a QOC grievance and the steps to process clinically involved grievances.	9/2019
Deleted Arbitration reference to filing timeframe from "Grievance Filing Timeframes" grid Rearranged DOI filing information and Reference to HIM.UM.08 Appeals for UM Decisions instructions for flow Updated turnaround times for filing a grievance and filing an appeal of a grievance throughout policy Updated the reference to the IN.QI.18 policy to CC.QI.17 throughout policy.	3/2020
Updated Step 1 – Grievance Expedited Grievances (Clinically urgent grievances) (An additional 10 from "calendar" to business days Updated Step 2 – Appeal of a Grievance (Excluding medical necessity decisions) (An additional 10 from "calendar" to business days may be requested if needed) Corrected Appeals of a grievance filing timeframe on page 8 from 30 calendar days to 60 calendar days	5/2020

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Corrected the revision log to add 2019 revisions	

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to a signature.

Manager Grievance & Appeals: _____

VP Compliance: _____