Indiana – Grievance

First Level – All Products

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Indiana – Grievance

First Level – All Products

When to Use the Process	For the resolution of **grievances** – this **does not** include issues related to a claim or service denial; refer to the appropriate Appeal process. (2) Follow appeal process for claim practices and adverse determinations underlined in the Definition of Grievance. (2)
Definitions	**Grievance** – Any dissatisfaction expressed by (or on behalf of) a member about: • A decision that the service is not medically necessary, experimental and investigational; • The availability, delivery, appropriateness, or quality of services; • Claims payment or handling; • Matters pertaining to the contractual relationship; • Based on rescission of coverage; • A decision concerning a prior authorization request (4)
Who Can Submit the Request?	The member. Anyone other than the member must have authorization. (2) & (4) Request for Authorization Letter & Form: (2)
In What Manner May the Request be Submitted?	Oral, written, or electronic. (2) & (4)

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First Level – All Products, Continued

Timeframe to Submit Request	Not specified.
Is Acknowledgement of the Request Required?	HMO/HMO-POS: Yes, within 3 business days of receipt. (4) PPO/Indemnity: Yes, within 5 business days of receipt. (2)
Who Must Receive Acknowledgement?	Grievant as stated in the Who Can Submit the Request? section. (2)
Resolution Timeframe	**All** grievances, not later than 20 business days from receipt. (4)
Is Extension of the Resolution Timeframe Permitted?	Yes. May be extended for up to 10 business days if written notice of delay is sent before end of the initial 20 business days. (4)

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First Level – All Products, Continued

Reviewer Requirements	The reviewer must: • Not have participated in the initial decision (2) • Not be a subordinate of the individual who made the initial decision. (2)
Resolution Notification Requirements Method	Within 5 business days of the decision, written or electronic notice (must ensure documents received and provide paper copy upon request). (2) & (4)
Resolution Notification Content Requirements	Notice must include: • The right to request a panel review • Procedures to initiate the panel review • Name, department, address & phone number of the health plan's representative to contact for more information about decision and appeal rights. (4)

Who Must Receive the Resolution Notification?	• **Member grievances**: the member
	• **Authorized Representative grievances** (non-provider): the authorized representative
	• **Provider grievances** (with authorization):
	  ○ The provider
	  ○ The member or their authorized representative (non-provider)
	(2) & (4)

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Indiana – Grievance

Second Level – All Products

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Indiana –Grievance

Second Level – All Products

When to Use the Process	For the resolution of **grievances** – this **does not** include issues related to a claim or service denial; refer to the appropriate Appeal process. (2) Follow appeal process for claim practices and adverse determinations underlined in the Definition of Grievance. (2)
Definitions	**Grievance** – Any dissatisfaction expressed by (or on behalf of) a member about: • A decision that the service is not medically necessary, experimental and investigational; • The availability, delivery, appropriateness, or quality of services; • Claims payment or handling; • Matters pertaining to the contractual relationship; • Based on rescission of coverage; • A decision concerning a prior authorization request (4)
Who Can Submit the Request?	The member. Anyone other than the member must have authorization. (2) & (4) Request for Authorization Letter & Form: (2)
In What Manner May the Request be Submitted?	Oral, written, or electronic. (2) & (4)

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Second Level – All Products, Continued

Timeframe to Submit Request	Not specified.
Is Acknowledgement of the Request Required?	HMO/HMO-POS: Yes, within 3 business days of receipt. (4) PPO/Indemnity: Yes, within 5 business days of receipt. (2)
Who Must Receive Acknowledgement?	Grievant as stated in the Who Can Submit the Request? section. (2) & (4)
Is Panel Review Notification Required?	Yes, at least 72 hours before the panel meeting. (4) Notice must include member's right to: • Appear in person before panel at a location convenient to the member during normal business hours (4) • Communicate with the panel if unable to appear in person. (4)
Resolution Timeframe	**All** grievances, not later than 45 business days from receipt. (4)
Is Extension of the Resolution Timeframe Permitted?	Not permitted. (4)

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Second Level – All Products, Continued

Reviewer Requirements	The **panel**:
	• Must include a minimum of 3 voting members unless otherwise required by the state (2)
	• May include internal Humana associates from various departments throughout the company and/or external non-Humana associates (2)
	• Reviewers must:
	  o Not have participated in the initial decision (2)
	  o Not be a subordinate of the individual who made the initial decision (2)
	• Must include at least one member who:
	  o Is knowledgeable of the medical condition, procedure, or treatment at issue (4)
	  o Is in the same profession as the treating provider (4)
	  o Does not have a direct business relationship with the member or provider at issue (4)

Resolution Notification Requirements Method	Within 5 business days of the decision, written or electronic notice (must ensure documents received and provide paper copy upon request). (2) & (4)
Resolution Notification Content Requirements	Notice must include name, department, address & phone number of the health plan's representative to contact for more information about decision and appeal rights. (4)

Who Must Receive the Resolution Notification?	• **Member grievances**: the member
	• **Authorized Representative grievances** (non-provider): the authorized representative
	• **Provider grievances** (with authorization):
	  o The provider
	  o The member or their authorized representative (non-provider)
	(2) & (4)

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Indiana – Appeal (Grievance)

First Level – HMO/HMO-POS/PPO/Indemnity

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Indiana – Appeal (Grievance)

First Level – HMO/HMO-POS/PPO/Indemnity

General Information	The requirements outlined below reflect the most stringent rule between federal (i.e., ERISA) and every state law.
When to Use the Process	An **appeal** regarding an **adverse determination.**
Definitions	**Adverse Determination** – a denial, reduction, termination of, or failure to provide or make payment: • In whole or in part for a benefit (Example: Applying the plan provisions and paying less than the total amount of expense submitted for a deductible, coinsurance or co-payment) (1) • Based on eligibility to participate in the plan (when a claim or appeal is made) (1) • Based on rescission of coverage (1) **Appeal** – a request for reconsideration of an adverse determination. (2)
Who Can Submit the Request?	The member. Anyone other than the member must have authorization. (1) (3) & (5) Request for Authorization Letter & Form: (2)
In What Manner May the Request be Submitted?	Oral, written, or electronic. (1) (3) & (4)

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First Level – HMO/HMO-POS/PPO/Indemnity, Continued

Timeframe to Submit Request	180 calendar days (from receipt of the **adverse determination**). (1) (3) & (5)
Is Acknowledgement of the Request Required?	**Step Therapy Protocol** exception cases: No (2) **HMO/HMO-POS**: Yes, within 3 business days of receipt (4), except cases involving Step Therapy Protocol exception requests (2). **PPO/Indemnity**: Yes, within 5 business days of receipt, except cases involving Step Therapy Protocol exception requests. (2)
Who Must Receive Acknowledgement?	Appellant as stated in the Who Can Submit the Request? section. (2)
Decision Timeframe	**All Step Therapy Protocol exception** cases, not later than 3 business days from receipt. (4) **All pre-service and concurrent care** adverse determinations, except cases involving Step Therapy Protocol exception requests, not later than 15 calendar days from receipt. (1) (3) (4) & (5) **All post-service** adverse determinations, except cases involving Step Therapy Protocol exception requests, not later than 20 business days from receipt. (1) (4) & (5)
Is Extension of the Decision Timeframe Permitted?	Not permitted. (1) & (3)

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First Level – HMO/HMO-POS/PPO/Indemnity, Continued

Reviewer Requirements	**Medical necessity or experimental/investigational** adverse determinations, the reviewer must: • Hold an active, unrestricted medical license • Be from the same or similar specialty who typically treats the medical condition or provides the treatment in question (1) & (3) **All** adverse determinations, the reviewer must: • Not have participated in the initial decision (1) (3) & (5) • Not be a subordinate of the individual who made the initial decision. (1) (3) & (5)
Decision Notification Requirements Method	Within 5 business days of the decision, written or electronic notice (must ensure documents received and provide paper copy upon request), ***except*** cases involving Step Therapy Protocol, written notice must be sent immediately. (1) (2) (3) & (4)
Decision Notification Content Requirements	**All upholds or partial overturns**: • The right to request a panel review • Procedures to initiate the panel review • The DOI website address • Name, department, address & phone number of the health plan's representative to contact for more information about decision and appeal rights. (1) (3) (4) & (5) **Overturns**, (1) (3) & (5)

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First Level – HMO/HMO-POS/PPO/Indemnity, Continued

Who Must Receive the Decision Notification?

Step Therapy Protocol exception appeals (4):

- The member or their authorized representative (non-provider)
- The provider

All other appeals:

- **Member appeals**: the member and prescriber for pharmacy appeals
- **Authorized Representative appeals** (non-provider): the authorized representative and prescriber for pharmacy appeals
- **Provider appeals** (with authorization):
    - The provider and prescriber for pharmacy appeals, if different.
    - The member or their authorized representative (non-provider)

(1) (2) (3) & (5)

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Indiana – Appeal (Grievance)

Second Level – HMO/HMO-POS/PPO/Indemnity

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Indiana – Appeal (Grievance)

Second Level – HMO/HMO-POS/PPO/Indemnity

General Information	The requirements outlined below reflect the most stringent rule between federal (i.e., ERISA) and every state law.
When to Use the Process	An **appeal** regarding an **adverse determination.**
Definitions	**Adverse Determination** – a denial, reduction, termination of, or failure to provide or make payment: • In whole or in part for a benefit (Example: Applying the plan provisions and paying less than the total amount of expense submitted for a deductible, coinsurance or co-payment) (1) • Based on eligibility to participate in the plan (when a claim or appeal is made) (1) • Based on rescission of coverage (1) **Appeal** – a request for reconsideration of an adverse determination. (2)
Who Can Submit the Request?	The member. Anyone other than the member must have authorization. (1) (3) & (5) Request for Authorization Letter & Form: (2)
In What Manner May the Request be Submitted?	Oral, written, or electronic. (1) (3) & (4)

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Second Level – HMO/HMO-POS/PPO/Indemnity, Continued

Timeframe to Submit Request	Not specified. (4)
Is Acknowledgement of the Request Required?	HMO/HMO-POS: Yes, within 3 business days of receipt. (4) PPO/Indemnity: Yes, within 5 business days of receipt. (2)
Who Must Receive Acknowledgement?	Appellant as stated in the Who Can Submit the Request? section. (2)
Is Panel Review Notification Required?	Yes, at least 72 hours before the panel meeting. (4) Notice must include member's right to: • Appear in person before panel at a location convenient to the member during normal business hours (4) • Communicate with the panel if unable to appear in person. (4)
Decision Timeframe	**All pre-service and concurrent care** adverse determinations, not later than 15 calendar days from receipt. (1) (3) (4) & (5) **All post-service** adverse determinations, not later than 30 calendar days from receipt. (1) (4) & (5)
Is Extension of the Decision Timeframe Permitted?	Not permitted. (1) (3) & (4)

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Second Level – HMO/HMO-POS/PPO/Indemnity, Continued

Reviewer Requirements	**Medical necessity or experimental/investigational** adverse determinations, at least one **panel reviewer** must: • Hold an active, unrestricted medical license; • Be from the same or similar specialty who typically treats the medical condition or provides the treatment in question (1) & (3) • Be in the same profession as the treating provider (4) **All** adverse determinations, the **panel reviewers** must: • Not have participated in the initial adverse decision or prior appeal decision (1) (3) & (5) • Not be a subordinate of the individual who made the initial adverse decision or prior appeal decision (1) (3) & (5) • Not have a direct business relationship with the member or the provider at issue (4)
Decision Notification Requirements Method	Within 5 business days of the decision, written or electronic notice (must ensure documents received and provide paper copy upon request). (1) (2) (3) & (4)
Decision Notification Content Requirements	**All medical necessity, experimental/investigational upholds or partial overturns, n**otice must include: • The right to request an external review by an IRO • Procedures to initiate the IRO review • The DOI website address • Name, department, address & phone number of the health plan's representative to contact for more information about decision and appeal rights (1) (3) (4) & (5) **All other upholds or partial overturns**, (1) (3) & (5) **Overturns**, (1) (3) & (5)

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Second Level – HMO/HMO-POS/PPO/Indemnity, Continued

Who Must Receive the Decision Notification?

Step Therapy Protocol exception appeals (4):
- The member or their authorized representative (non-provider)
- The provider

All other appeals:
- **Member appeals**: the member
- **Authorized Representative appeals** (non-provider): the authorized representative
- **Provider appeals** (with authorization):
  - The provider
  - The member or their authorized representative (non-provider)

(1) (2) (3) & (5)

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Indiana – External Review

All Products, Except Dental

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Indiana – External Review

All Products, Except Dental

When to Use the Process	**For all medical necessity, experimental, investigational and rescissions when urgent care is needed, upholds or partial overturns.** The member must first exhaust the internal process. (4)
Who Can Submit the Request?	The member or their authorized representative. (4)
In What Manner May the Request be Submitted?	Written to the insurer (4)
Timeframe to Submit Request	120 calendar days (from receipt of adverse determination) (4)

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1 ERISA/Federal requirement
2 Business decision
3 URAC standards
4 State specific requirement
5 NCQA standards

All Products, Except Dental, Continued

Is an Appointment of Representation (AOR) Required?	Yes (2)
Is an Acknowledgement of the Request Required?	No provision.
Who Must Receive Acknowledgement?	No provision.
External Reviewer Requirements	IRO (4)
IRO Selection Process	The Insurer will select the IRO on an equal and rotating basis from a list located on the state's web site IRO Rotation Assignment List. (4) Refer to the Indiana Independent Review Organization Selection Procedures for assistance.

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1 ERISA/Federal requirement
2 Business decision
3 URAC standards
4 State specific requirement
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All Products, Except Dental, Continued

What Information Needs to be Submitted and by Whom for the External Review?	Submit the following information to the IRO: • Copy of member's policy; • Medical records; • Supporting documentation used to make the decision, and; • Criteria used and clinical reasons for the decision.
Timeframe in which Information Must be Submitted	Within 5 business days of receipt of request. (2)
What if Humana Overturns its Decision Prior to the External Review Decision?	Upon receipt of new information, and within 15 calendar days, the insurer may reconsider their previous decision. Inform the IRO that their review is pended until the additional information is reviewed by Humana and a decision is reached. (2) & (4) If the decision is an uphold, send the additional information to the IRO and notify the IRO to continue the review. (2) If the decision is an overturn, notify the member or authorized representative and the IRO. The external review process is then terminated. (2) & (4)

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All Products, Except Dental, Continued

Decision Timeframe	Not later than 15 business days of receipt. (4)
Is an Extension of the Decision Timeframe Permitted?	No provision
Decision Notification Requirements Method	Written or electronic notice within 72 hours of the decision (must ensure documents received and provide paper copy upon request). (4)
Decision Notification Content Requirements	Notice must include the: • Effect of the determination on the covered individual; and, • Manner in which the insurer may be expected to respond to the determination. (4)
Who Must Send the Decision Notification?	IRO (4)

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1 ERISA/Federal requirement
2 Business decision
3 URAC standards
4 State specific requirement
5 NCQA standards

All Products, Except Dental, Continued

Who Must Receive the Decision Notification?	The member or their authorized representative and insurer. (4)
Overturn Requirements	Must pay or authorize service or treatment.
Fee Payment Details	Humana pays the entire cost of the IRO. (4)

1 ERISA/Federal requirement
2 Business decision
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5 NCQA standards

Indiana – Expedited External Review

All Products, except Dental

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Indiana – Expedited External Review

All Products, except Dental

When to Use the Process	**For all expedited/urgent care upholds or partial overturns including expedited/urgent care situations where coverage has been rescinded.** The member must first exhaust the internal process. (4)
Who Can Submit the Request?	The member or their authorized representative. (4)
In What Manner May the Request be Submitted?	Written to the insurer (4)
Timeframe to Submit Request	120 calendar days (from receipt of adverse determination) (4)

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1 ERISA/Federal requirement
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All Products, except Dental, Continued

Is an Appointment of Representation (AOR) Required?	Yes
Is an Acknowledgement of the Request Required?	No provision.
Who Must Receive Acknowledgement?	No provision.
External Reviewer Requirements	IRO (4)
IRO Selection Process	The Insurer will select the IRO on an equal and rotating basis from a list located on the state's web site IRO Rotation Assignment List. (4) Refer to the Indiana Independent Review Organization Selection Procedures for assistance.

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All Products, except Dental, Continued

What Information Needs to be Submitted and by Whom for the External Review?	Submit the following information to the IRO (address): • Copy of member's policy; • Medical records; • Supporting documentation used to make the decision, and; • Criteria used and clinical reasons for the decision.
Timeframe in Which Information Must be Submitted	No provisions.
What if Humana Overturns its Decision Prior to the IRO's Decision?	Upon receipt of new information, and within 72 hours, the insurer may reconsider their previous. Inform the IRO that their review is pended until the additional information is reviewed by Humana and a decision is reached. (2) & (4) If the decision is an uphold, send the additional information to the IRO and notify the IRO to continue the review. (2) If the decision is overturned, notify the member or authorized representative and the IRO. The external review process is then terminated. (2) & (4)
Decision Timeframe	Not later than 72 hours of receipt. (4)

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1 ERISA/Federal requirement
2 Business decision
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All Products, except Dental, Continued

Is an Extension of the Decision Timeframe Permitted?	No provisions.
Decision Notification Requirements Method	Written or electronic notice within 72 hours after the external appeal is filed (must ensure documents received and provide paper copy upon request). (2) & (4)
Decision Notification Content Requirements	Notice must include the: • Effect of the determination on the covered individual; and, • Manner in which the insurer may be expected to respond to the determination. (4)
Who Must Send the Decision Notification?	IRO (4)
Who Must Receive the Decision Notification?	The member or their authorized representative and insurer. (4)
Overturn Requirements	Must pay or authorize service or treatment.
Fee Payment Details	Humana pays the entire cost of the IRO. (4)

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