PHYSICIANS HEALTH PLAN OF NORTHERN INDIANA, INC.

PHP INSURANCE COMPANY OF INDIANA, INC

POLICY & PROCEDURE

Policy Title: Appeal Policy and Procedure for PHPNI and PHPIC		**Origination Date:**	**9/01/1997**
Policy No.: GA0013 **Section: Quality - Appeals**		**Effective Date:**	**1/11/2019**
Approved By: Gail Doran, COO		**Revision Date:**	**6/16/2021**
Approved Date: 3/17/17		**Review Date:**	**1/11/2023**

Purpose

To ensure all appeals and Independent Review Organization (IRO) requests are handled in a consistent manner in accordance with all appropriate state and federal laws.

Policy P-HUM 33.a,b (i)

It is the Policy of Physicians Health Plan of Northern Indiana, Inc. (PHP), that the Appeal process shall be in compliance with Department of Labor and State of Indiana guidelines, timeframes and regulations. PHP will maintain a formal process to consider appeals for medical necessity decisions that resulted in a non-authorization of services including the availability of a standard appeal for non-urgent cases and expedited appeal for cases involving urgent care. Urgent and standard appeals are available upon request, to any patient, provider, or facility rendering service. P-HUM 33.b (iii)

Definitions

Appeal

a) A verbal or written request to PHP by a consumer, ordering physician, or prescriber to change its decision regarding an adverse benefit determination, or a request for appeal as outlined in the Member Certificate of Coverage regarding eligibility. Expedited appeals will be completed within 72 hours. Appeals will be resolved within 15 calendar days. P-HUM 33b (ii); P-HUM 39

b) Designated Representative
An individual the member has appointed to assist or represent them with an appeal, expedited appeal, or external appeal. This person may include, but not be limited to, physicians, other providers, attorneys, friends, or family members. They must identify their designated representative to us in writing, though, in order to prevent the disclosure of your medical information to unauthorized persons.

c) External Appeal (Sometimes identified as an Independent Review Organization)
An appeal process in which an IRO reviews certain appeal and expedited appeal decisions PHP made and determines whether to uphold or reverse them.

d) Filing Time Limit P-HUM 33 b.(ii); P-HUM 38
All requests for reconsideration of an adverse benefit determination must be received within the following time frames once the adverse benefit determination has been made.

P-HUM 33 b.(ii); P-HUM 38

Level Requested	Group
Urgent Appeal	48 hours
Appeal	180 days
IRO(External appeal)	120 days

e) Final Internal Adverse Benefit Determination
The upholding of an adverse benefit determination at the conclusion of the internal appeals process or an adverse benefit determination internal appeals process has been deemed exhausted.

f) Independent Review Organization (or IRO)
An organization licensed by the Indiana Department of Insurance to conduct external appeals.

g) Urgent Care Appeals P-HUM 33.a; P-HUM 38
An expedited appeal process allows for an accelerated review by PHP of a medical necessity denial decision. It is available only when a reasonable lay person believes that life, health, or ability to reach and maintain maximum function would be seriously jeopardized due to a sickness, disease, condition, injury, or disability, or in the opinion of the member's physician would subject the member to severe pain that cannot be adequately managed. If these conditions are met, a decision will be rendered as soon as possible, but no later than 48 hours from the time of the service request.

TOLL-FREE ACCESS (IC-27-13-10-5)
PHP provides a toll-free telephone number (1-800-982-6257, Extension 361) for local or long-distance callers through which members may obtain information on their rights. PHP utilizes the AT&T Language Line which provides access to translation services staff who speak a number of different languages and who are available to assist the Grievance and Appeal Coordinator in speaking with members of non-English-speaking origin.

Procedure(s)
P-HUM 33 b.(i)
Appeals may be submitted to PHP verbally or in writing, either by the member or by a person the member has appointed in writing as his or her designated representative, including a health care provider. An appeal that is initiated by the Indiana Department of Insurance (IDOI) will follow the appeal process in accordance with IDOI requirements. PHP shall review this Policy & Procedure for any appropriate revisions on an annual basis.

This Policy & Procedure does not govern any issue governed or covered, in whole or in part, by the Indiana Medical Malpractice Act. All such claims must be brought in accordance with applicable Indiana law.
P-HUM 33.b (ii) P-HUM 34.a

1. When a Lack of Certification notification letter is sent to the requesting providers and to the request originators including facilities rendering service(s) and patients, it will contain a statement allowing 180 days for a member to submit an appeal for reconsideration of the following:
    - Non-certification determination.

- A statement sent to the patient, provider, and/or facility rendering service(s) that they may submit written comments, documents, records, and other information relating to the case.
- Summation of the member's appeal rights.

P-HUM 33.b (ii)

2. When an appeal is received in response to a non-certification (pre-service) determination, the Grievance and Appeals Coordinator and the Medical Director will, within 1 calendar day, forward the appeal to a review panel. Within 3 business days an acknowledgment letter will be sent to the member and/or the member's designated representative. See Process Guideline Appeal Hearing Workflow. (See last page for appeals that can be conducted in person).

3. Independent Medical Reviewer – All appeal considerations will be conducted by Clinix or Federal Hearings and Appeal Services, a URAC accredited company, who shall assign appeal considerations to health professionals who:
   - Are clinical peers;
   - Hold an unrestricted, active license or certification to practice medicine or a health profession in a state or territory of the United States; P-HUM 35.a
   - Unless expressly allowed by state or federal law or regulation, are located in a state or territory of the United States when conducting an appeals consideration. P-HUM 35.b
   - Are Board-certified by a specialty Board approved by the American Board of Medical Specialties (Doctors of Medicine); or the Advisory Board of Osteopathic Specialists from the major areas of clinical services (for Doctors of Osteopathic Medicine); or
     i. The Advisory Board of Osteopathic Specialist from the major areas of clinical services (doctors of osteopathic medicine); or
     ii. The American Dental Association's (ADA) specialty boards or the American Board of General Dentistry (ABGD); or
     iii. The American Board of Podiatric Surgery (ABPS) or the American Board of Podiatric Medicine (ABPM).P-HUM 35.e (i) (ii) (iii) (iv)
   - Are in the same profession and in similar specialty as typically manage the medical condition, procedure, or treatment as mutually deemed appropriate; P-HUM 35.c
   - Are neither the individual who made the original Lack of Certification decision, nor a subordinate of such an individual; and P-HUM 35.d
   - Who will follow the guidelines, as per this Policy.

4. As part of the Appeals process, PHP and the independent medical reviewer considering the Appeal shall:
   - Provide the patient, provider, or facility rendering service the opportunity to submit written comments, documents records, and other information relating to the case P-HUM 34.a
   - Take into account all documents, comments, records, and all other information related to the case that was submitted with the appeal by patients, providers, and/or facilities rendering service(s), without regard to whether such information was submitted or considered in the initial consideration of the case/request for certification. P-HUM 34.b

5. For each appeal case they accept, the appeal reviewer will attest through written documentation that they have a scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review, and current, relevant experience and/or knowledge to render a determination for the case under review. P-HUM 37 a. and b.

6. If the person making the appeal is a provider of care or a physician, the Independent Medical Reviewer may choose to speak directly with that person or his/her representative.

   P-HUM 33 b (ii); P-HUM 39
7. In the case of a standard appeal, the Independent Medical Reviewer will provide a decision within 14 calendar days of receipt of the request for appeal including written notification of the appeal decision to the patient and attending physician or other ordering provider or facility rendering service.

   P-HUM 33 b (ii); P-HUM 38
8. In the case of the expedited appeal, the Chief Operating Officer ensures the Medical Director communicates the Independent Medical Reviewers decision to the originator of the appeal within 72 hours (3 calendar days) from the initiation of the Appeal to PHP. Written confirmation of the expedited appeal determination will be provided within three calendar days to the patient, and his or her designated representative, if applicable and the attending physician or other ordering provider or facility rendering service. Information may be conveyed orally and followed up with a written confirmation.

   P-HUM 33 b (ii) P-HUM 40.a,b,and c
9. A medical necessity appeal must be conducted and resolved within 15 calendar days. The Grievance and Appeal Coordinator will provide a written appeal response within 5 business days of resolution which will include the following:
   - The principal reason(s) for the determination to uphold the non-certification; P-HUM 40 a
   - A statement that the clinical rationale used in making the appeal decision will be provided in writing, upon request; and P-HUM 40 b
   - Information about additional appeal mechanisms, if available through the Plan sponsor for ASO. P-HUM 40 c
   - In the instance of a first level appeal, PHP will implement the decision of the first level clinical appeal if it overturns the initial denial. P-HUM 34 c

   P-HUM 33 b (ii)
10. External Review (IRO): In the event of continued denial the member may file a written request for an IRO (External Appeal) with PHP within 120 days after they receive the notice of the Appeal or Expedited Appeal decision. In accordance with Indiana law, IRO's will be assigned on a sequential basis through a list of certified review organizations maintained by the Indiana Department of Insurance. The assignment of IROs will be made by PHP from the approved list on the IDOI website. PHP will access and rely on appropriate clinical expertise in rendering independent review determinations. P-HUM 42.a
    P-HUM 33 b (ii)
11. **Standard IRO:** Upon receipt of the IRO (External appeal), an acknowledgement letter will be sent to the member and/or member's designated representative within 3 business days. The person or organization appealing will be provided with written notification of the final determination and the notice will include the rational for the final determination and the process for seeking further review, if available. The IRO must render a decision within 15 business days after appeal is filed. Notification of the decision will be sent to the member and/or the member's designated representative by the IRO and/or PHP within 72 hours of the decision. P-HUM 42.c
    P-HUM 33 b (ii)
    Urgent IRO: In determinations for cases involving urgent care, the IRO will notify and render the determination within 72 hours from the date the consumer initiated the independent review. The IRO will notify the member within 72 hours of the decision for urgent or expedited appeals. P-HUM 38; P-HUM 42.d

The IRO reviewer may not have been involved in the original determination under appeal. PHP is responsible for any additional costs of the IRO (External Appeal) for fully-insured and Indigo Individual members. The member is required to cooperate with the IRO by providing or authorizing the release of any necessary medical information that PHP hasn't already provided. At all times during the External Appeal process, the member is permitted to submit any relevant information to the IRO. The IRO will not have any direct financial interest in PHP or the outcome of the independent review. The determination of the IRO is binding on PHP. P-HUM 34.c; P-HUM 42.a, b, e

12. All Appeals will be recorded in the case file by the Grievance and Appeal Coordinator.

13. The Appeals record is contained in the applicable case file which contains, at minimum:
    - The name of the patient, provider, and/or facility rendering service(s); P-HUM 41.a
    - Copies of all correspondence from the patient, provider, and/or facility rendering service(s) and correspondence from the contracted Independent Medical Review service to the patient, provider, and/or facility rendering service(s) regarding the appeal; P-HUM 41.b
    - Dates of all appeal reviews, documentation of actions taken, and final resolution or determinations; and P-HUM 41.c
    - Minutes or transcripts of appeal proceeding. P-HUM 41.d
    - Name and credentials of the clinical peer that meets the qualifications in standard P-HUM 35. P-HUM 41.e

14. All Appeals will be tracked on a quarterly basis by the Grievance and Appeal Coordinator, and analyzed for trending purposes by the COO, and Medical Director. The analysis of Appeals for trending purposes will be provided to the Quality Improvement Committee on a quarterly basis.

PHP utilizes Clinix and Federal Hearings and Appeal Services, a URAC Accredited Company, to have their Independent Medical Reviewers review all appeal cases unless requested in person. If an appeal is requested for an in person appeal, a panel is selected to review the case. Clinix or Federal Hearing and Appeal Services will make the medical determination and PHP is bound by their decision as set forth in the contract. Please note this statement only applies to appeals, all IRO's (External Appeals) will be assigned on a sequential basis through a list of certified review organizations maintained by the Indiana Department of Insurance.

When appeals are conducted in the office the member and/or the appointed authorized legal representative will be able to attend the appeal hearing. The member or designated representative will present information to the appeal panel and answer any questions. After the appeal panel's questions are completed the member or appointed designated representative will be asked to leave. The appeal panel will then make their determination.

References:

Standard / Regulation #:

IC27-13-10
45 CFR § 147.128
45 CFR § 147.136
29 CFR § 2560.503-1
29 CFR § 147.128
DOL TR 2013-01

Accreditation Standard: **URAC: HUM 33, 34, 35, 37, 38, 39, 40, 41, 42**

Reviewed By: Medical Director, Executive Vice President, Director of Medical Management, Director of Client Services, Client Services and Operations Specialist