



BAPTIST HEALTH PLAN

P&P TITLE: Filing an Oral or Written Grievance

POLICY NUMBER: 272-001-07

REPLACES: 272-001-06

POLICY EFFECTIVE DATE: 7/01/2014

LATEST REVISION DATE: 6/12/2014

ORIGINATION DATE: 2/16/2006

PRIMARY DEPARTMENT: MEDICAL AFFAIRS

OTHER AFFECTED DEPARTMENTS: CUSTOMER SERVICE, HEALTHCARE OPERATIONS, PROVIDER SERVICES & REGULATORY COMPLIANCE

This policy applies to the following lines of business: (Check those that apply.)

<input checked="" type="checkbox"/> COMMERCIAL	<input type="checkbox"/> GOVERNMENT PROGRAMS	<input type="checkbox"/> MARKETPLACE	<input type="checkbox"/> OTHER
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Policy Statement:

The following policy and procedure (P&P) establishes a written procedure for maintaining, filing, investigating and resolving grievances for Indiana health benefit plan enrollees by Baptist Health Plan (BHP) in accordance with IC-27-13-10 and as required by the Affordable Care Act (ACA).

Policy:

In compliance with IC 27-13-1-15, BHP defines Grievance as a written or oral “complaint submitted in accordance with the formal grievance procedure of a health maintenance organization by or on behalf of the enrollee or subscriber regarding any aspect of the health maintenance organization relative to the enrollee or subscriber.”

IC 27-8-28-6 defines “grievance” as any dissatisfaction expressed by or on behalf of a covered individual regarding:

1. “A determination that a service or proposed service is not appropriate or medically necessary;
2. A determination that a service or proposed service is experimental or investigational;
3. The availability of participating practitioners and organizational providers;
4. The handling or payment of claims for health care services; or
5. Matters pertaining to the contractual relationship between:
 - a. A covered individual and an insurer; or
 - b. A group policyholder and an insurer; or
6. An insurer’s decision to rescind an accident and sickness insurance policy; and

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7. 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.”

Procedure:

Filing an Oral or Written Grievance

1. The enrollee, authorized representative or practitioner/organizational provider acting on the enrollee’s behalf may file a grievance orally or in writing within sixty (60) days following either the incident leading to the Grievance or the enrollee’s receipt of notice of denial of benefits.
2. BHP provides the following toll free number for initiating a grievance: (800) 787-2680. This number is staffed during normal business hours (8:30 AM - 5:30 PM) Monday through Friday.
3. Grievances are accepted in English, however, if the enrollee does not speak English, but speaks Spanish, a Spanish-speaking representative will be provided.
4. Grievances are considered as being filed on the first date it is received, either by telephone or in writing.
5. If an enrollee designates a representative to file a grievance on their behalf, an appropriate HIPAA compliant authorization must be on file and current designating a representative by the enrollee to initiate a grievance or an appeal.

Resolution of Grievances

1. BHP’s Grievance/Complaint Coordinator or designee, will acknowledge receipt of a grievance orally or in writing within three (3) business days.
2. Resolution of the grievance will include:
 - Documentation of the substance of the grievance and any actions taken
 - An investigation of the substance of the grievance, including any aspects involving clinical care
 - Notification to the enrollee or subscriber of the disposition of the grievance and the right to initiate an internal appeal process that accommodates the clinical urgency of the situation will be strictly adhered to.
 - At least one (1) staff member of the Appeals Department available to resolve the complaint/grievance
 - Resolution as expeditiously as possible, but not more than twenty (20) business days after the grievance is filed
3. If resolution is not possible within the twenty (20) day timeframe due to circumstances beyond our control, we shall:



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- Notify the enrollee or subscriber in writing of the reason for the delay on or before the nineteenth (19th) business day; and
 - Resolve the grievance within thirty (30) business days from the date the grievance was filed.
 - If the requested information has not been received, we will make a determination based on the information in our possession.
4. BHP's Grievance/Complaint Coordinator shall notify the enrollee and practitioner/organizational provider in writing of the resolution of a non-expedited grievance within five (5) business days after completing the investigation.
 5. The grievance resolution notice will contain the following:
 - The decision reached,
 - The reasons, policies, and procedures that are the basis of the decision,
 - Notice of the enrollee's or subscriber's right to appeal the decision, and
 - The department, address and telephone number through which an enrollee may contact a qualified representative to obtain more information about the decision or the right to appeal.

Expedited Grievance

An expedited review is available if the following are met:

1. The service has not been performed; and
2. A physician with knowledge of the enrollee's medical condition believes that the standard appeal time frames could seriously jeopardize the enrollee's life or health or could subject the enrollee to severe pain that cannot be adequately managed.

Expedited grievances will be resolved with a determination sent within seventy-two (72) hours of our receipt of sufficient information regarding the grievance. We will communicate our decision by telephone to the enrollee's ordering physician or practitioner/organizational provider, and will also provide written notice of our determination to the enrollee, the enrollee's ordering physician or practitioner/organizational provider, and the facility rendering the service if applicable.

Culturally and Linguistically Appropriate Manner

BHP must provide notice to enrollees, in a culturally and linguistically appropriate manner. BHP is considered to provide relevant notices in a culturally and linguistically appropriate manner if notices are provided in a non-English language as described in the 2010 interim final regulations based on thresholds of the number of people who are literate in the same non-English language.



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If an applicable threshold is met, notice must be provided upon request in the non-English language. In addition, BHP must also include a statement in the English versions of all notices, prominently displayed in the non-English language, offering the provision of such notices in the non-English language. Once a request has been made by an enrollee, BHP must provide all subsequent notices to the enrollee in the non-English language. In addition, to the extent BHP maintains a customer assistance process that answers questions or provides assistance with filing claims and appeals, BHP must provide such assistance in the non-English language.

Note: The state of Indiana does not currently meet the threshold requirement and therefore BHP is not required at this time to provide notices in non-English languages.

Reviewed by (Signature/Date): Not Officially Signed P&P – See P&P Binder

Approved by (Signature/Date): Not Officially Signed P&P – See P&P Binder



BAPTIST HEALTH PLAN

P&P TITLE: Internal Appeal of Grievance Decision-IN

POLICY NUMBER: 272-002-05

REPLACES: 272-002-04

POLICY EFFECTIVE DATE: 7/01/2014

LATEST REVISION DATE: 5/28/2014

ORIGINATION DATE: 2/16/2006

PRIMARY DEPARTMENT: MEDICAL AFFAIRS

OTHER AFFECTED DEPARTMENTS: REGULATORY COMPLIANCE, CUSTOMER SERVICE, HEALTHCARE OPERATIONS & PROVIDER SERVICES

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<input type="checkbox"/> COMMERCIAL	<input type="checkbox"/> GOVERNMENT PROGRAMS	<input type="checkbox"/> OTHER
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Policy Statement:

This policy and procedure (P&P) addresses the timely resolution of oral and written appeals of grievance decisions by Baptist Health Plan (BHP) for Indiana enrollees in accordance with IC 27-13-10 and as required by the Affordable Care Act (ACA).

Procedure:

Filing an Internal Appeal of a Grievance Decision

1. A request for an internal appeal must be submitted in writing within 180 calendar days of receipt of a determination.
2. If an enrollee designates a representative to file an internal appeal of grievance on their behalf, a current HIPAA compliant authorization must be on file designating a representative by the enrollee to initiate an internal appeal of grievance.
3. The request for an internal appeal, must include:
 - the initial denial letter,
 - the number of claims in question,
 - the date(s) of service,
 - a summary of any previous communication you have had with BHP regarding this denial, and
 - any additional pertinent medical information to the attention of the Appeals Coordinator.
4. Enrollees, authorized representatives and practitioners /organizational providers may request a board eligible or certified Physician in the appropriate specialty or subspecialty area to conduct the internal appeal relating to any denial of a service or coverage.

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POLICY NUMBER: 272-002-05

5. Appeals will be acknowledged orally or in writing within three (3) business days after receipt of the appeal being filed as required by IC-27-13-10-8.
6. Documentation of the substance of the appeal and the actions taken will be entered under the enrollee's name in CCMS.
7. Documentation will include investigation of the substance of the appeal, including any aspects of the clinical care involved that relate to the appeal issue.
8. Enrollees, authorized representatives, and ordering practitioners/organizational providers will be notified of the disposition of the appeal, and of further remedies allowed by law.
9. Required standards for timeliness in responding to appeals, providing notice of the disposition of the appeal and the right to initiate an external appeal that accommodates the clinical urgency of the situation as required by IC-27-13-10.1 will be strictly adhered to.

Filing an Expedited Internal Appeal of a Grievance Decision

1. An expedited internal appeal process is available if the enrollee is hospitalized, or in the opinion of the treating provider, a review under a standard time frame could, in the absence of immediate medical attention; result in any of the following:
 - place the health of the enrollee or, with respect to a pregnant woman, the health of the enrollee or the unborn child in serious jeopardy;
 - cause serious impairment to bodily functions or serious dysfunction of a bodily organ or part;
 - subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is subject of the claim; or
 - as related to a recommended or requested service determined to be experimental or investigational, cause the service to be significantly less effective if not promptly initiated.
2. If the above criteria are met, the enrollee may qualify to proceed with an expedited external review (See P&P 272-003, External Appeal of Grievance Decision) at the same time as an expedited internal appeal.
3. An expedited internal appeal may be requested orally by contacting the Appeals Coordinator, but must be followed up in written request.

Appeal Determination

1. Appeals will be reviewed by an individual who was not involved in the matter giving rise to the complaint or in the initial investigation of the complaint.
2. In the case of an appeal from the proposal, refusal, or delivery of a health care procedure, treatment, or service, one (1) or more individuals will be assigned to resolve the appeal who:
 - have knowledge of the medical condition, procedure or treatment at issue;
 - are in the same licensed profession as the provider who proposed, refused, or delivered the health care procedure, treatment or service;

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- are not involved in the matter giving rise to the appeal or the previous grievance process; and
 - do not have a direct business relationship with the enrollee or the health care provider who previously recommended the health care procedure, treatment, or service giving rise to the grievance.
3. BHP will allow enrollees the opportunity to appear in person to present their appeal information or to communicate through other appropriate means if they are unable to appear in person.
 4. An appeal of a grievance decision will be resolved as expeditiously as possible and with regard to the clinical urgency of the appeal. A non-expedited appeal of a grievance must be resolved not later than thirty (30) calendar days after the appeal is filed.
 5. If the request qualifies for expeditious handling due to clinical urgency, expedited review will be completed within seventy-two (72) hours of our receipt of the appeal request. Our physician's decision will be communicated by telephone to the attending physician or ordering provider. We will also provide written notice of our determination to the patient enrollee, the attending physician or ordering provider, and the facility rendering the service.
 6. Written notification of the appeal decision will be sent within five (5) business days of the decision.
 8. If the appeal is not resolved as required, BHP will file a report with the Indiana Department of Insurance during the quarter in which the violation occurred which will contain the following:
 - The number of appealed grievance decisions that were not resolved as required under IC 27-13-10-8 (c)
 - The reason each appeal was not resolved as required under subsection (c)

Appeal Notices of Determination

Appeal resolution/determination notices will contain the following:

1. The decision reached by BHP
2. The reasons, policies or procedures that are the basis of the decision
3. Notice of the enrollee's or subscriber's right to further remedies allowed by law, including the right to review by an independent review organization under IC 27-13-10.1
4. The department, address and telephone number through which the enrollee may contact a qualified representative to obtain more information about the decision or the right to an appeal

Authorized Representatives

1. BHP will not take action against a practitioner/organizational provider for representing an enrollee in the appeal process. Practitioners/organizational providers may represent



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enrollees as appellants in the appeal process to the extent allowed by Indiana law as stated in IC 27-13-10-12.

2. If a practitioner/organizational provider files an appeal with us on behalf of a member, the provider will be deemed to be the member's representative and correspondence concerning the grievance will be sent to both the enrollee and their practitioner/organizational provider.
3. In all other situations in which a representative requests an appeal of a grievance on the enrollee's behalf, BHP must receive a signed HIPAA compliant authorization from the enrollee before we can discuss or correspond with the representative. If we do not receive a signed authorization, we will continue to research the appeal, but will respond only to the enrollee and practitioner/organizational provider, unless a signed authorization is received.

Culturally and Linguistically Appropriate Manner

BHP must provide notice to enrollees, in a culturally and linguistically appropriate manner. BHP is considered to provide relevant notices in a culturally and linguistically appropriate manner if notices are provided in a non-English language as described in the 2010 interim final regulations based on thresholds of the number of people who are literate in the same non-English language. If an applicable threshold is met, notice must be provided upon request in the non-English language. In addition, BHP must also include a statement in the English versions of all notices, prominently displayed in the non-English language, offering the provision of such notices in the non-English language. Once a request has been made by an enrollee, BHP must provide all subsequent notices to the enrollee in the non-English language. In addition, to the extent BHP maintains a customer assistance process that answers questions or provides assistance with filing claims and appeals, BHP must provide such assistance in the non-English language.

Note: The state of Indiana does not currently meet the threshold requirement and therefore BHP is not required at this time to provide notices in non-English languages.

Reviewed by (Signature/Date): Not Officially Signed P&P – See P&P Binder

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P&P TITLE: External Appeal of Grievance Decision

POLICY NUMBER: 272-003-05

REPLACES: 272-003-04

POLICY EFFECTIVE DATE: 7/01/2014

LATEST REVISION DATE: 06/12/2014

ORIGINATION DATE: 2/16/2006

PRIMARY DEPARTMENT: MEDICAL AFFAIRS

OTHER AFFECTED DEPARTMENTS: REGULATORY COMPLIANCE, CUSTOMER SERVICE, HEALTHCARE OPERATIONS & PROVIDER SERVICES

This policy applies to the following lines of business: (Check those that apply.)

<input type="checkbox"/> COMMERCIAL	<input type="checkbox"/> GOVERNMENT PROGRAMS	<input type="checkbox"/> OTHER
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Policy Statement:

This policy and procedure (P&P) is to establish guidelines by Baptist Health Plan (BHP) for determining when a request qualifies for review by an Independent Review Organization (IRO) for Indiana health benefit plan enrollees in accordance with IC 27-13-10.1 and as required by the Affordable Care Act (ACA).

Policy:

If an Adverse benefit determination is affirmed by BHP in internal appeal in whole or in part, the enrollee, authorized person, or provider acting in behalf of the enrollee with the enrollee's consent may request review by an IRO of the affirmed adverse determination that qualifies for review by IRO in accordance with Indiana requirements.

Procedure:

Requesting an External Review

1. A request for an external review by an independent review entity (IRE) of a claim denied, on the basis that the service is not medically necessary or is experimental or investigational, may be made within 120 calendar days after exhausting the internal appeal process, if the following conditions are met:
 - BHP or our designee has rendered a medical necessity, or experimental or investigational denial of service or coverage;
 - the enrollee has completed our internal appeal process, or BHP has failed to make a timely determination or notification; and
 - the enrollee was eligible on the date of service, or if a prospective denial, the enrollee was enrolled and eligible to receive covered benefits under the health benefit plan on the date the proposed service was requested.

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2. The enrollee shall not pay any of the costs associated with the services of an IRO. All costs must be paid by the Plan.
3. An external review shall not be afforded if:
 - the subject of the enrollee's denial has previously gone through the external review process and the IRE found in our favor; and
 - no relevant new clinical information has been submitted to BHP since the IRE found in our favor.
4. Upon BHP's receipt of the written request for external review, an ***Authorization for the Use and Disclosure of Individually Identifiable Health Information to an Independent Review Entity (IRE) form*** will be provided to the enrollee. This form must be completed in order for the IRE to obtain all necessary medical records from both BHP and any practitioner/organizational provider utilized for review purposes regarding the decision to deny, limit, reduce, or terminate coverage.
5. The enrollee will not be subject to any form of retaliation by BHP for requesting an external review with an IRO.
6. An enrollee may utilize the assistance of other individuals including physicians, attorneys, friends, and family throughout the review process.
7. Enrollees will be permitted to submit additional information relating to the proposed service throughout the review process.
8. The enrollee is required to provide any requested medical information and submit written consent authorizing the release of necessary medical information for the purpose of external review.

Assignment of IRO

1. BHP will assign IRO's sequentially from a list of IROs that are certified by the IN DOI using the link: <http://www.in.gov/cgi-bin/idoi/ssDisplay-2.pl?file=iro&letter=a>. BHP will not repeat assignments until the entire rotation list has been utilized.
2. The IRO shall assign a medical review professional who is board certified in the applicable specialty for resolution of an appeal.
3. The IRO and the medical review professional conducting the external review this chapter may not have a material professional, familial, financial, or other affiliation with any of the following:
 - BHP
 - Any officer, director, or management employee of BHP
 - The practitioner/organizational provider that is proposing the service.
 - The facility at which the service would be provided.



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- The development or manufacture of the principal drug, device, procedure, or other therapy that is proposed by the treating physician.

Non-Expedited Requests

1. Non-expedited requests for external review by an IRO will be submitted to the IRO no later than five (5) business days from the date the appropriate request for reconsideration is received.
2. The IRO must make a decision within fifteen (15) business days of receiving the case for review.
3. The IRO must notify the enrollee and the insurer of the determination within seventy-two (72) hours of making the determination regarding a non-expedited review.

Expedited Requests

BHP will allow an enrollee or the enrollee's representative to file a written request with BHP for an external appeal of the affirmed adverse determination on an expedited basis if review under the standard timeframe could, in the absence of immediate medical attention, result in any of the following:

1. Placing the health of the enrollee (or in the case of a pregnant woman the health of the covered person or the unborn child) in serious jeopardy;
2. Serious impairment to bodily function; or serious dysfunction of a bodily organ or part;
3. Subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is subject of the claim; or
4. As related to a recommended or requested service determined to be experimental or investigational, cause the service to be significantly less effective if not promptly initiated.

IRO Determination

1. The IRO must make a decision regarding an expedited review within seventy-two (72) hours of the appeal being filed.
2. The IRO must notify the insurer and the member of the expedited decision within twenty-four (24) hours.
3. If the IRO's determination is to reverse our appeal decision, we will notify the enrollee and his or her provider in writing of the steps we will be taking to comply with the determination
4. The IRO's determination is binding on BHP and the covered person except to the extent there are remedies available under applicable state or federal law.
5. An enrollee or designated representative with the enrollee's consent may not file more than (1) external appeal of an adverse determination that was affirmed on internal appeal.

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6. BHP will promptly supply the IRO with any information requested by the IRO necessary for completing their review.

Additional Information Received

1. If at any time during an external review the enrollee submits information to BHP that is relevant to the resolution of the case under IC 27-13-1-8, and was not considered by BHP under IC 27-13-10, BHP will reconsider the resolution under IC 27-13-10-8 and the IRO shall cease the review process until the reconsideration is completed.
2. BHP will notify the enrollee of its decision within seventy-two (72) hours after the information is submitted for reconsideration if the issue qualifies as expedited and is related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the enrollee's life or health; or ability to reach and maintain maximum function.
3. For non-expedited reconsiderations of additional information submitted after request for IRO review, BHP will notify the enrollees of their determination within fifteen (15) days after the information is submitted for reconsideration.
4. If the determination reached is adverse to the enrollee, the enrollee may request that the IRO resume the external review.

Culturally and Linguistically Appropriate Manner

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