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**IOWA  
MEMBER GRIEVANCE PROCEDURES  
PROBLEM RESOLUTION**

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**MEMBER COMPLAINT AND APPEAL PROCEDURES**

**Sanford Health Plan makes decisions in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Members, health care Practitioners and/or Providers with knowledge of the Member's medical condition, authorized representative of the Member and/or an attorney may appeal any adverse decision by Sanford Health Plan. The Member or his/her legal guardian may designate in writing to Sanford Health Plan an authorized representative to act on his/her behalf. This written designation of representation from the Member should accompany the request. The following types of denials will be considered for the appeals process.**

**Types of Denials:**

1. Benefits Denial – a denial that is specifically excluded from the Member's benefits package and is not considered a medical necessity denial.
2. Medical Necessity Denial – a denial of care of services that could be considered a covered benefit depending on the circumstances. Examples:
  - a. Experimental Treatments
  - b. Cosmetic procedures
  - c. Pharmaceutical Prior Authorizations
  - d. Access to Out-of-Network Practitioners and Providers
  - e. Continued care and services
3. Claims Denials – denials based on timely and accurate filing of claims and failure to request authorization of services.

**Types of Appeals:**

**Appeal:** A request to change any previous adverse decision made by Sanford Health Plan. An appeal can be for a pre or post service request.

**Expedited Appeal:** A request to change a previous decision made by Sanford Health Plan for an urgent care request.

**External Appeal:** An external appeal is a request for an independent, external review of the final determination made by Sanford Health Plan through its internal appeals process.

**Complaint:** An oral or written expression of dissatisfaction. It is the policy of Sanford Health Plan to make reasonable efforts to resolve Member and Practitioner and/or Provider complaints. A process has been established for Members (or their designees) and Practitioners and/or Providers to use when they are dissatisfied with the Plan, its Practitioners or Providers, or processes.

**Inquiry:** A telephone call regarding, eligibility, plan interpretation, plan policies and procedures, or plan design. It is the policy of Sanford Health Plan to address Member, Practitioner and Provider inquiries through informal resolution over the telephone whenever possible. If the resolution is not satisfactory to the inquirer, he or she will be instructed of his or her rights to file a verbal or written complaint.

Audit trails for complaints, appeals and denials are provided by the Plan's information system and an Access database which includes documentation of the complaint and/or appeal by date, service, procedure, and reason. The denial file includes documentation telephone notification, including the date; the name of the person spoken to; the Member; the service, procedure, or admission certified; and the date of the service, procedure, or admission denial and reason for denial. If the Plan indicates authorization by use of a number, the number must be called the "authorization number."

**Complaints and Appeals can be made for up to 180 days from denial notification.**

**Complaint and Postservice Appeal Procedure**  
If any Member or authorized representative acting on behalf of the Member, has a question, complaint or other problem regarding claims payment for a

postservice(s) or those services already received, any aspect of the Plan's services, his or her relationship with the Plan and its Practitioners or Providers other than a complaint regarding certification, or authorization decision, the Member or the authorized representative should contact the Plan by calling or sending a written complaint to the following address:

Sanford Health Plan  
PO Box 91110  
Sioux Falls, SD 57109-1110  
Phone: (800) 752-5863 or  
(605) 328-6800

The Member or his/her legal guardian may designate in writing to Sanford Health Plan an authorized representative to act on his/her behalf. This written designation of representation from the Member should accompany the complaint filed.

The Plan will make a decision and notify the Member in writing of its proposed resolution within *sixty (60) calendar days* of receipt of the complaint. If the issue is unsatisfactorily resolved, the Member will be informed of his or her right to appeal the decision. Member notification of the complaint response will be made in writing or by telephone, which will be logged for reference.

Any adverse decision notification will advise the Member of the opportunity to submit written comments, documents or other information related to the appeal. For complaints related to quality of care, the Plan will, at a minimum, state that the Member's complaint was received and investigated and will follow the above timelines for response.

If the Member or a Member's authorized representative appeals an adverse determination, Members do not have the right to attend or have a representative attend the first level review, but Members are entitled to:

1. Send written comments, documents, records and other material relating to the request; and
2. Receive reasonable access to documents, records and other information relevant to the request, free of charge.

Full and thorough investigation of the substance of the appeal, including any aspects of clinical care involved, will be coordinated by the Complaint Coordinator. A person who was not the subordinate of any person involved in the initial determination will review the complaint/postservice appeal. For medical necessity postservice appeals only, a Practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment will review the appeal, however, the Practitioner who made the initial adverse determination may review the appeal and overturn the previous decision. The Plan will document the substance of the appeal and any actions taken.

Determinations will be made within *sixty (60) calendar days* of receipt of the appeal request. Written or electronic notification of the decision will be provided to the Member and those providers involved in the appeal within *sixty (60) calendar days* of receipt of the request.

If the postservice appeal response is adverse, the Member shall be informed of their additional right to contact the IA Division of Insurance or a court of law.

Iowa Commissioner of Health  
330 Maple St.  
DesMoines, IA 50139  
Phone: (515) 282-4227

The Member shall also be informed of their additional right under certain circumstances to initiate the external review process. Refer to the section *INDEPENDENT, EXTERNAL REVIEW OF FINAL DETERMINATIONS* for details on this process.

### **Prior Authorization (Preservice) Appeals**

The Appeals procedure for Prior Authorization or Preservice must be followed when a determination has been made that is adverse to the Member. An adverse medical determination does not meet the Plan's requirements for medical necessity, appropriateness of health care setting or level of care, and the requested service is therefore denied or payment is reduced. This type of denial could be in relation to experimental treatments, cosmetic

procedures, pharmaceutical coverage or access to Nonparticipating Practitioners or Providers. An adverse determination could also be a denial of a service that is specifically excluded from the Member's benefit package.

Two types of initial appeals are available to Members or their authorized representative (as designated in writing by the Member), Practitioners and Providers to address concern regarding medical determination and prior authorization or preservice request decisions: an expedited appeals process and a standard appeals process.

### 1. Expedited Appeals Process

An expedited appeals procedure is used when the condition is emergent or urgent in nature, as defined by the Benefits Policy (under the Iowa State Specific Guidelines for Medical Management and Benefit Decision Protocols section - #3.).

An expedited review of a prior authorization (preservice) denial determination not to authorize must be utilized if the Member or Practitioner acting on behalf of the Member believes that an expedited determination is warranted. This can be done by oral or written notification to the Plan. The Plan will accept all necessary information (electronic or by telephone) for review from the Practitioner of care. A designated physician advisor will conduct the review and will be available to discuss the case with the attending Practitioner on request. For medical necessity reviews only, a Practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment will review the request. However, the Practitioner who made the initial adverse determination may review the appeal and overturn the previous decision.

The determination will be made and provided to the Member, attending Practitioner and those Providers involved in the appeal via telephone by the Utilization Management Department as expeditiously as the Member's medical condition requires but no later than within *seventy-two (72) hours* of receipt of the request. The Member, attending Practitioner and those Providers involved in the appeal will receive

written or electronic notification within *three (3) calendar days* of the telephone notification.

If the expedited review is a concurrent review determination, the service must be continued without liability to the Member until the Member or the representative has been notified of the determination.

### 2. Standard Appeals Process

A standard appeal may be requested by a Member, his or her authorized representative, Practitioner or Provider by writing or telephoning the Member Services Department at 1-800-752-5863 or (605) 328-6800 if the determination for a request for service was adverse to the Member. The appeals process is included in the Member's initial denial letter.

If the Member or Member's authorized representative files an appeal request of an adverse determination, they will be advised that they are entitled to:

1. Submit written comments, documents, records and other information related to the request; and
2. Receive reasonable access to documents, records and other information relevant to the request, free of charge.

The attending Practitioner and the Member will be made aware by telephone or in writing of their responsibility for submitting the documentation required for resolution of the appeal if needed. Documentation may include sending copies of part or all of the medical record and/or a written statement from the Practitioner. Only the necessary information that pertains to the case in question will be requested. Documentation of the substance of the preservice appeal and any actions taken will be recorded.

Full and thorough investigation of the substance of the appeal, including any aspects of clinical care involved, will be completed by the Complaint Coordinator. At least one Physician advisor representing the same or appropriate specialty who is conversant with the appeal process, whose scope of practice includes the services or treatment being reviewed and who was not involved in the initial

determination provided. However, the Practitioner who made the initial adverse determination may review the appeal and overturn the previous decision.

Determinations will be made within *thirty (30) calendar days* of receipt of the appeal request. Written or electronic notification of the decision will be provided to the Member, attending Practitioner and those Providers involved in the appeal within *thirty (30) calendar days* of receipt of the request.

### **Written Decision Process**

The written decision for the Standard (Preservice and Postservice) and Expedited Review (Preservice only) must contain the following information:

1. The specific reason for the decision in easily understandable language;
2. The titles and qualifications, including specialty, of the person or persons participating in the first level review process (Reviewer names are available upon request);
3. Reference to the evidence, benefit provision, guideline, and/or protocol used as the basis for the decision and notification that the Member on request can have a copy of the actual benefit provisions, guidelines, and protocols free of charge;
4. Notification the Member can receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to their appeal (preservice, postservice and expedited) and determination by requesting this from the Plan by telephone or in writing;
5. Notification and instructions on how the Practitioner can contact the physician, appropriate behavioral health (for behavioral health reviews) to discuss the determination.
6. If the preservice appeal response is adverse, the Member shall be informed of the additional right to contact the IA Division of Insurance or a court of law.

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7. Description of the next level appeal within the organization and/or the right to appeal to an external review organization (for medical necessity denials only) as well as any written procedures as it pertains. Final denial letters will contain information on the circumstances under which appeals are eligible for external review and information on how the Member can seek further information about these rights.
8. If the adverse determination is completely overturned, the decision notice must state the decision and the date.

### **INDEPENDENT, EXTERNAL REVIEW OF FINAL DETERMINATIONS (Iowa Code 514J, IA Rule 191-76):**

#### **A. Notification of right to independent, external review**

For Iowa residents, an independent, external review of their appeal will be re-evaluated through the Iowa Insurance Division. The mechanism for the appeal of a denial of coverage based on medical necessity will follow the examples listed in NCQA Surveyor Guidelines. Also, with the Member's permission, the Plan may refer an appeal directly to the independent review organization without conducting internal review. The Plan's written notification of the Standard Review Determination to the Member will include the following information:

1. Evidence the Member was covered by the Plan at the time the service or treatment was proposed or received;
2. Evidence the Member has been denied coverage based on a determination by the Plan that the proposed or received service or treatment does not meet the definition of medical necessity;
3. Evidence the Member, or the Member's treating health care Provider acting on behalf of the Member, has exhausted all internal appeal mechanisms provided under the Plan's evidence of coverage.
4. Notification that the request for an external review must be filed within *sixty (60) days* of receipt of the coverage decision from the Plan.

Notification to Members about the independent, external appeal program includes a general communication to Members, at least annually, to announce the availability of the right to independent, external review.

### **B. Filing a request for external review**

To have a denied medical claim re-evaluated by an independent, external review agent, the Member, or the Member's treating health care Provider acting on behalf of the Member, must file the following request:

1. The request for external review to the insurance commissioner must be filed within *sixty (60) days* of receipt of the Plan's coverage decision.
2. A request made to the Division of Insurance, 330 Maple Street, Des Moines, Iowa 50319;
3. A copy of the Plan's coverage decision must accompany the written request for an external review;
4. A \$25 filing fee is required unless the Member is requesting that the fee be waived. The check should be made payable to the Insurance Division. The filing fee shall be refunded if the Member prevails in the external review process. If a waiver is requested, the request shall include an explanation of why the Member is requesting that the fee be waived.

### **C. Certification of Request**

The commissioner shall have *two (2) business days* from receipt of a request for an external review to certify the request. The commissioner shall certify the request if all of the following criteria listed in Section A 1-4 in this Independent, External Review Section are satisfied.

The commissioner shall notify the Member, or the Member's treating health care Provider acting on behalf of the Member, and the Plan in writing of the certification. The Plan has *three (3) business days* from the date of receipt to contest the commissioner's certification decision. If the commissioner finds that the request for external review is not eligible for certification, the commissioner, within *two (2)*

*business days*, shall notify the Member, or the Member's treating health care Provider acting on behalf of the Member, in writing of the reasons that the request for external review is not eligible for certification. If the commissioner finds that the request for external review is eligible for certification, notwithstanding the contest by the Plan, the commissioner shall notify the Plan in writing of the reasons for upholding the certification.

### **D. The external review process**

The external review process shall meet the following criteria:

1. The Plan, within *three (3) business days* of a receipt of an eligible request for an external review from the commissioner, or within *three (3) business days* of receipt of the commissioner's denial of the Plan's contest of the certification of the request, whichever is later, shall do all of the following:
  - a. Select an independent review entity from the list certified by the commissioner. The independent review entity shall be an expert in the treatment of the medical condition under review. The independent review entity shall not be a subsidiary of, or owned or controlled by, the Plan, or owned or controlled by a trade association of Plans of which the Plan is a member.
  - b. Notify the Member, and the Member's treating health care Provider, of the name, address, and telephone number of the independent review entity and of the Member's and treating health care Provider's right to submit additional information.
  - c. Notify the selected independent review entity by facsimile that the Plan has chosen them to do the independent review and provide sufficient descriptive information to identify the type of experts needed to conduct the review.
  - d. Provide to the commissioner by facsimile a copy of the notices sent to the Member and to the selected independent review entity.
2. The independent review entity, within *three (3) business days* of receipt of the notice, shall select

a person to perform the external review and shall provide notice to the Member of a brief description of the person including the reasons the person selected is an expert in the treatment of the medical condition under review. The independent review entity does not need to disclose the name of the person. A copy of the notice shall be sent by facsimile to the commissioner.

3. The Member, or the Member's treating health care Provider acting on behalf of the Member, may object to the independent review entity selected by the Plan or to the person selected as the reviewer by the independent review entity by notifying the commissioner and Plan within *ten (10) days* of the mailing of the notice by the independent review entity. The commissioner shall have *two (2) business days* from receipt of the objection to consider the reasons set forth in support of the objection to approve or deny the objection, to select an independent review entity if necessary, and to provide notice of the commissioner's decision to the Member, the Member's treating health care Provider, and the Plan.
4. The Plan, within *fifteen (15) days* of the mailing of the notice by the independent review entity, or within *three (3) business days* of a receipt of notice by the commissioner following an objection by the Member, whichever is later, shall do all of the following:
  - a. Provide to the independent review entity any information submitted to the Plan by the Member or the Member's treating health care Provider in support of the request for coverage of a service or treatment under the Plan's 's appeal procedures.
  - b. Provide to the independent review entity any other relevant documents used by the Plan in determining whether the proposed service or treatment should have been provided.
  - c. Provide to the commissioner a confirmation that the information required in paragraphs "a" and "b" has been provided to the independent review entity, including the date the information was provided.
5. The Member, or the Member's treating health care Provider, may provide to the independent review entity any information submitted under any internal appeal mechanisms provided under the Plan's 's evidence of coverage, and other newly discovered relevant information. The Member shall have *ten (10) business days* from the mailing date of the notification of the person selected as the reviewer by the independent review entity to provide this information. The independent review entity may reasonably decide whether to consider any information provided by the Member or the Member's treating health care Provider after the *ten (10) day* period.
6. The independent review entity shall notify the Member and the Member's treating health care Provider of any additional medical information required to conduct the review within *five (5) business days* of receipt of the documentation required under subsection 4. The Member or the Member's treating health care Provider shall provide the requested information to the independent review entity within *five (5) days* after receipt of the notification requesting additional medical information. The independent review entity may reasonably decide whether to consider any information provided by the Member or the Member's treating health care Provider after the *five (5) day* period. The independent review entity shall notify the commissioner and the Plan of this request.
7. The independent review entity shall submit its external review decision as soon as possible, but not later than *thirty (30) days* from the date the independent review entity received the information required under subsection 4 from the Plan. The independent review entity, for good cause, may request an extension of time from the commissioner. The independent review entity's external review decision shall be mailed to the Member or Member's treating health care Provider acting on behalf of the Member, the Plan and the commissioner.
8. The confidentiality of any medical records submitted shall be maintained pursuant to applicable state and federal laws.

#### **D. Expedited review**

The Member's treating health care Provider shall directly contact the Plan or organized delivery system for an expedited review if the Member's treating health care Provider states that the delay would pose an imminent or serious threat to the Member. The Member's treating health care Provider and the Plan shall select, within *seventy-two (72) hours*, an independent review entity to conduct the external review. In the event that the Member's treating health care Provider and the Plan cannot reach an agreement upon the selection of an independent review entity, the Member's treating health care Provider shall notify the commissioner who shall select an independent review entity.

The Plan and the Member's treating health care Provider shall provide any additional medical information to the review entity. In the event the Plan does not find that a delay would pose an imminent or serious threat to the Member, the Member's treating health care Provider may ask the commissioner to immediately review the request for certification as an expedited review.

A review by the commissioner shall follow the *seventy-two (72) hour* expedited review time period.

#### **E. Other External Review Provisions**

1. A requirement that all reasonable fees and costs of the independent, external review entity be paid by the Plan or organized delivery system.
2. A provision directing each Plan to file with the Commissioner, an annual report including the number of independent, external reviews requested, the number of external review requests certified by the Commissioner, and the number of coverage decisions upheld by an independent, external review entity.
3. Immunity for an independent, external review entity from liability for damages arising out of a determination, unless the determination is made in bad faith or involves gross negligence.
4. That the standard of review to be used by an independent, external review entity is whether the health care service or treatment denied by the Plan or organized delivery system was medically

necessary as evidenced by the Member's Policy, and consistent with clinical standards of medical practice.

5. That the review decision by the independent, external review entity is binding upon the Plan and that the findings of fact by the independent, external review entity are conclusive and binding on appeal and in any subsequent proceeding or action involving the same facts. The Plan shall follow and comply with the review decision of the independent review entity conducting the review, or the decision of the court on appeal. The Plan and the Member's treating health care Provider shall not be subject to any penalties, sanctions, or award of damages for following and complying in good faith with the review decision of the independent review entity conducting the review or decision of the court on appeal.
6. The Member or the Member's treating health care Provider may appeal the independent, external review entity's decision in Polk County District Court or the district court in the county in which the Member resides. A petition for judicial review must be filed within *fifteen (15) business days* after issuance of the review decision.
7. The Complaint Coordinator will report to the Plan's Physician Quality Committee with regard to the number and nature of reported appeals and their resolutions. The Plan shall report annually to the Commissioner of Insurance or Health as appropriate, the description of the medical review determinations appeal procedures, those appeals in which denials are upheld, and those appeals that are not resolved within *thirty (30) days*.