

MINNESOTA MEMBER COMPLAINT AND APPEAL PROCEDURES

Sanford Health Plan of Minnesota 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 of Minnesota. The Member or his/her legal guardian may designate in writing to Sanford Health Plan of Minnesota 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.

A. 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 prior authorization of services for out-of-network services.

B. Types of Appeals:

1. **Appeal:** A request to change any previous adverse decision made by Sanford Health Plan of Minnesota. An appeal can be for a pre or post service request.
2. **Expedited Appeal:** A request to change a previous decision made by Sanford Health Plan of Minnesota for an urgent care request.
3. **External Appeal:** An external appeal is a request for an independent, external review of the final determination made by Sanford Health Plan of Minnesota through its internal appeals process.

C. Definitions

Complaint: An oral or written expression of dissatisfaction against the Plan which has been submitted by a complainant and which is not under litigation. It is the policy of Sanford Health Plan of Minnesota to make reasonable efforts to resolve Member, Practitioner and Provider complaints. A process has been established for Members (or their designees), Practitioners and Providers to use when they are dissatisfied with the Plan, its Practitioners or Providers, or processes. Examples of complaints are the scope of coverage for health care services; eligibility issues; denials, cancellations, or nonrenewals of coverage; administrative operations; and

the quality, timeliness, and appropriateness of health care services provided.

Complainant: This is a Member, applicant, or former Member or anyone acting on behalf of a Member, applicant, or former Member, who submits a complaint.

Utilization Review: Means the evaluation of the necessity, appropriateness, and facilities used by a Member for the purpose of determining medical necessity of the service or admission.

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 authorized (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 (certification) number."

D. Complaint & Medical Review Determination Process

1. Informal/Oral Complaints:

A complainant may orally submit a complaint to the Member Services Department. Member Services will make every effort to resolve the complaint. The Member Services Department will investigate the complaint and provide for informal discussions. If the oral complaint is not resolved to the complainant's satisfaction within *ten (10) business days* of receipt of the complaint, the Plan will provide a complaint form to the complainant, which must be completed and returned to the Member Services Department for further consideration. The Plan will assist the complainant in completing this form, or will complete the form and mail it to the complainant for a signature, if the complainant asks for assistance.

At any time, the complainant may also file a complaint with the Commissioner of Health regarding network benefits, either in writing or by calling (651) 201-5100, or toll free 1-800-657-3916 or the Commission of Commerce regarding Supplemental (Out-of-Network) benefits at (651) 296-2488, or toll free at 1-800-657-3602.

2. Formal/Written Complaint Process:

A complainant can seek further review of a complaint not resolved through the formal process. The steps in this complaint and appeal process are outlined below.

- a. **Formal Complaint Review.** You or your authorized representative may send your written request for review, including comments, documents, records and other information relating to the complaint, the reasons you believe

you are entitled to benefits and any other supporting documents to:

Sanford Health Plan of Minnesota
Member Services Department
PO Box 90447
Sioux Falls, SD 57109-0447

We will notify the complainant within *ten (10) business days* that we received the written complaint, unless the complaint has been resolved to the complainant's satisfaction within those *ten (10) business days*.

Upon request and at no charge to you, you will be given reasonable access to and copies of all documents, records and other information relevant to your complaint.

We will review your complaint and notify you of our decision in accordance with the following timelines:

b. For PreService Claims (services for which prior approval by us is a requirement for coverage)

Urgent Request

If the service request is urgent, you or your Practitioner may request an **expedited** review. Within *seventy-two (72) hours* of such request, a decision will be made via telephone to you, your Practitioner and those Providers involved in the provision of the service. You, your Practitioner and those Providers involved in the provision of the service will receive written notification within *three (3) calendar days* of the phone notification.

Non-Urgent Request

If the service request concerns non-urgent services, a written decision will be made to you, your Practitioner and those Providers involved in the provision of the service within *ten (10) business days* from the date the Plan receives your request. If the decision is not to authorize your request, telephone notification will be made within *one (1) working day* to you, your Practitioner and those Providers involved in the provision of the service.

c. PostService Claims.

A decision and written notification on your complaint will be made to you, your Practitioner and those Providers involved in the provision of the service within *thirty (30) calendar days* from the date the Plan receives your request. This time period may be extended by up to fourteen (14) days if you agree.

All notifications described above will comply with applicable law.

E. Appeal Process.

NOTE: When, due to a medical reason, an initial determination is made not to cover a health care service prior to or during an ongoing service, an appeal must be submitted by the Member or Member's authorized representative to the Plan within 180 days following the written notice of initial determination. The Member or his/her legal guardian may designate in writing to Sanford Health Plan of Minnesota an authorized representative to act on his/her behalf. This written designation of representation from the Member should accompany the appeal.

1. Preservice Appeal (for utilization review for a medical determination).

If the Member or a Member's authorized representative appeals an adverse response, 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, will be coordinated by the Complaint Coordinator. A person who was not involved in the initial determination nor the subordinate of any person involved in the initial determination will review the appeal. 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 appeal. The Plan will document the substance of the appeal and any actions taken.

When an initial determination is to deny your request, you or your authorized representative may submit a request for appeal. If the request concerns non-urgent services, a written decision on your complaint will be made to you and your Practitioners and/or Providers involved in the appeal within *thirty (30) calendar days* from the date the Plan receives your request.

In certain circumstances, this time period may be extended *fourteen (14) additional days*. In such cases the Plan will notify you in advance, of the reasons for the extension. Per NCQA guidelines, the member must voluntarily agree to this extension.

Expedited Appeal Process

An expedited appeal process is used when the condition is emergent or urgent in nature, as defined by the Benefits Policy and in this Policy.

An expedited review of a prior authorization (preservice) denial determination not to authorize

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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.

The determination will be made and provided to the Member and those Practitioners and/or Providers involved in the appeal via telephone by the Utilization 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 and those Practitioners and/or Providers involved in the appeal will receive written 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. Postservice appeal

If after the first level of complaint review of a postservice claim, your request was denied, you or your authorized representative may submit a request for appeal either in writing or by telephone. Written requests should include any relevant documents, issues, comments and additional information as appropriate and be sent to:

Sanford Health Plan of Minnesota
Member Services Department
PO Box 90447
Sioux Falls, SD 57109-0447

The Member Services Department will provide the complainant with the option of either a written reconsideration, or a hearing before the Member Appeals Committee either in person or over the telephone. Hearings and written reconsideration shall include the receipt of testimony, correspondence, explanations, or other information from the complainant, staff persons, administrators, Practitioners, Providers, or other persons as deemed necessary for a fair appraisal and resolution of the complaint. During your appeal, upon your request we will provide you, free of charge, reasonable access to all documents, records and other information relevant to your appeal.

Full and thorough investigation of the substance of the appeal, including any aspects of clinical care, will be coordinated by the Complaint Coordinator. A person who was not involved in the initial determination nor the subordinate of any person

involved in the initial determination will review the appeal. 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 appeal. Appeals concerning non-clinical issues will be reviewed by the Member Services Manager, or designee, in accordance with the Plan document. The Plan will document the substance of the appeal and any actions taken.

We will review your appeal and written notice of the decision and all key findings will be given to the complainant within *thirty (30) calendar days* of the Member Services Department's receipt of the complainant's written notice of appeal. If a complainant appeals by hearing, written notice of the decision and all key findings will be given to the complainant within *forty-five (45) calendar days* of the Member Services Department's receipt of the complainant's written notice of appeal.

In certain circumstances, this time period may be extended *fourteen (14) additional days*. In such cases the Plan will notify you in advance, of the reasons for the extension. Per NCQA guidelines, the member must voluntarily agree to this extension.

F. Written Notification Process for Appeals

The written decision for the Appeal reviews will contain the following information:

1. A complete summary of the review findings;
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. The specific reason for the decision in easily understandable language;
4. 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;
5. The relationship between the Member's diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision;
6. Notification the Member can receive, upon request and free of charge, reasonable access and copies of all documents, records and other information relevant to the Member's benefit request;
7. Notification and instructions on how the Practitioner can contact the physician or appropriate behavioral health (for behavioral health reviews) reviewer to discuss the determination.
8. Notice of the Member's right to contact the Commissioner of Health either in writing or by calling (651) 201-5100 or toll free 1-800-657-3916 or the Commission of Commerce regarding supplemental benefits at (651) 296-2488 or toll

free 1-800-657-3602.

9. Notice of the Member's right to initiate the external appeals process and the procedure for initiating the process. 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.
10. If the adverse determination is completely overturned, the decision notice must state the decision and the date.

G. External Complaint Procedures:

1. If your complaint is denied based on our medical necessity criteria, you have the right to request an external review upon receiving notice of our decision on your complaint. If your complaint is denied for any other reason, you have the right to request external review upon notice of our decision at the completion of the internal appeal process. However, if the complaint relates to a malpractice claim, the complaint shall not be subject to the internal appeal process.
2. To initiate the external review process, you may submit a written request for an external review to the Commissioner of Health (651-282-5600 or 1-800-657-3916). This written request must be accompanied by a \$25 filing fee payable to the Center for Health Dispute Resolution. This fee may be waived by the Commissioner in cases of financial hardship. The Plan must participate in this external review, and must pay the cost of the review which exceeds the \$25 filing fee.
3. Upon receipt of the request for external review, the external reviewer must provide immediate notice of the review to the complainant and to the Plan. Within *ten (10) business days*, the Member and the Plan must provide their reviewer with any information they wish to be considered. The Member (who may be assisted or represented by a person of their choice) and the Plan shall be given an opportunity to present their versions for the facts and arguments. Any aspect of the external review involving medical determinations must be performed by a health care professional with expertise in the medical issue being reviewed.
4. An external review must be made as soon as possible, but no later than *forty (40) calendar days* after receipt of the request for external review. Prompt written notice of the decision and the reasons for it must be sent to the Member, the Commissioner of Health or Commissioner of Commerce, and to the Plan.
5. The results of the external review are non-binding on the Member and binding on the Plan. The Plan may seek judicial review of the decision under certain circumstances.
6. 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.