
SOUTH DAKOTA MEMBER GRIEVANCE PROCEDURES

PROBLEM RESOLUTION

MEMBER GRIEVANCE 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 determination 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 (Adverse Determinations) will be considered for the appeals process.

Definitions

Adverse determination: Means any of the following:

- a) A determination by the Plan that, based upon the information provided, a request by a Member for a benefit upon application of any Utilization Review technique does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be Experimental or Investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit;
- b) The denial, reduction, termination, or failure to provide or make payment in whole or in part, for a benefit based on a determination by the Plan of a Member's eligibility to participate in the benefit plan; or
- c) Any Prospective (preservice) Review or retrospective (postservice) review determination that denies, reduces, terminates, or fails to provide or make payment, in whole or in part, for a benefit.

Grievance: A written complaint, or oral complaint (if the complaint involves an Urgent Care Request), submitted by or on behalf of a Member regarding:

- a) Availability, delivery, or quality of Health Care Services;
- b) Claims payment, handling, or reimbursement for Health Care Services; or
- c) Any other matter pertaining to the contractual relationship between a Member and the health carrier. A request for an expedited review need not be in writing.
- d) An appeal (by NCQA definition) is a request to change a previous decision made by the Plan.

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 and Practitioner and/or 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 Grievance.

Urgent care situation: A degree of illness or injury which is less severe than an Emergency Condition, but requires prompt medical attention within twenty-four (24) hours. Urgent care request means a request for a health care service or course of treatment with respect to which the time periods for making a non-Urgent Care Request determination could:

- (1) Seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, based on a prudent layperson's judgment; or
- (2) In the opinion of a Practitioner and/or Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

In determining whether a request is "urgent," the Plan shall apply the judgment of a Prudent Layperson as defined in the Benefits Policy. A Practitioner and/or Provider, with knowledge of the Member's medical condition, who determines a request to be "urgent" within the meaning of subdivisions (1) and (2) in this paragraph shall be treated as an Urgent Care Request.

Types of Adverse determinations

Types of Adverse determinations include but are not limited to:

1. Benefits Denial – a denial that is specifically **excluded** from the Member’s benefits package or is not considered a Medical Necessity Denial.
2. Medical Necessity Denial – a denial of care of services that could be considered a Covered Service depending on the circumstances. Examples:
 - a. Experimental Treatments
 - b. Cosmetic procedures
 - c. Pharmaceutical authorizations (Certifications)
 - d. Access to Out-of-Network Practitioners and/or Providers
 - e. Continued care or services

Types of Grievances (Appeals)

There are two types of Grievances:

1. Those involving Adverse Determinations and
2. Those not involving Adverse Determinations (i.e. Claims Denials – denials based on timely and accurate filing of claims or failure to request authorization of services.)

These grievances can be of the following types:

1st Level Grievances for Prospective (preservice) or Retrospective (postservice) Reviews: A request to change a previous Adverse Determination made by Sanford Health Plan.

- A **prospective grievance** is a request to change an Adverse Determination that the Plan must approve in whole or in part in advance of the Member obtaining care or services.
- A **retrospective grievance** is a request to change an Adverse Determination for care or services already received by the Member.

Expedited Grievance for Urgent Care Reviews: A request to change a previous Adverse Determination made by Sanford Health Plan for an Urgent Care Request.

Additional Voluntary (2nd Level) Reviews: A request to change an Adverse Determination made at the 1st Level Grievance Review Process.

External Review: An external review is a request for an independent, external review of a *medical necessity* final determination made by Sanford Health Plan through its external appeals process.

Audit Trails

Audit trails for Adverse Determinations and Grievances are provided by the Plan’s Information System and an Access database which includes documentation of the Adverse Determination and/or Grievance by date, service, procedure, and reason. The Grievance file includes telephone notification, and documentation indicating 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 Adverse Determination and reason for determination. If the Plan indicates authorization by use of a number, the number must be called the "Authorization (Certification) number."

Filing Deadline

Grievances can be made for up to *one hundred eighty (180) days* from notification of the Adverse Determination.

Within *one hundred eighty (180) days* after the date of receipt of a notice of an Adverse Determination sent to a Member or the Member’s Authorized Representative (as designated in writing by the Member), the Member or their Authorized Representative may file a Grievance with the Plan requesting a **first level review** of the Adverse Determination.

The Member or the Authorized Representative should contact the Plan by calling or sending a written Grievance to the following address: Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110. Phone: (800) 752-5863 or (605) 328-6800.

1st Level Standard Review Procedure for Complaints (Grievances NOT involving Adverse Determination)

A standard appeal may be requested by a Member, his or her representative (as designated in writing by the Member) or Practitioner and/or Provider by writing or telephoning the Member Services Department at 1-800-752-5863 or (605) 328-6800. The Grievance process is included in the Member's initial determination letter.

Upon receipt of the Grievance, the Plan shall designate a person or persons to conduct the standard review. The Plan shall provide the Member or their Authorized Representative with the name, address and telephone number of a person designated to coordinate the standard review on behalf of the Plan.

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.

The attending Practitioner and the Member will be made aware of their responsibility for submitting the documentation required for resolution of the Grievance within *three (3)* working days of receipt of the Grievance.

The Plan will notify the Member or their Authorized Representative of the determination in writing or electronically within *twenty (20)* working days of receipt of Grievance.

Lack of Necessary Information

If the Health Plan is unable to make a decision due to lack of necessary information or for reasons beyond its control, it will notify the Member or the Member's Authorized Representative of what specific information is necessary to make the decision on or before the *twentieth (20)* working days after receipt of the request. In lieu of notifying the Member, the Plan can notify the Practitioner of the information needed if the request for healthcare services came from the Practitioner. The decision time frame will be extended once, for up to *ten (10)* working days after the date of notifying the Member or the Member's Authorized Representative of the failure to submit sufficient information as requested.

If the Member or a Member's Authorized Representative files a Grievance for an Adverse Determination, a thorough investigation of the substance of the Grievance will be conducted by an individual designated by the Plan. A person who was not involved in the initial determination nor the subordinate of any person involved in the initial determination will review the Grievance.

The Plan will document the substance of the Grievance and any actions taken. Full investigation of the substance of the Grievance, will be coordinated by the Grievance Coordinator.

If the 1st Level Standard Review determination is adverse, the Member shall be informed of the following additional rights:

(a) To request an Additional Voluntary (2nd level) review after receipt of this notice at which the Member or an Authorized Representative will be notified within *five (5)* working days of their rights and responsibilities to participate in the review panel; or

(b) To contact the SD Division of Insurance at:

SD Dept. of Revenue & Regulation
Division of Insurance
445 East Capitol Avenue
Pierre, SD 57501-3185

Phone: (605) 773-3563
Fax: (605) 773-5369

(c) Or, upon completion of the Plan's Grievance Procedures, to file a civil suit in a court of competent jurisdiction.

Grievance Procedure involving Adverse Determinations

If the Member or a Member's authorized representative (as designated in writing by the Member) files a Grievance for 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.

The attending Practitioner and/or Provider and the Member will be made aware of their responsibility for submitting the documentation required for resolution of the Grievance within *three (3)* working days of receipt of the Grievance.

Full and thorough investigation of the substance of the Grievance, including any aspects of clinical care involved will be coordinated by the Grievance 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 Grievance. 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, 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 Grievance and any actions taken.

Upon receipt of a Grievance or other problem regarding an Adverse Determination for a prospective (preservice) or retrospective (postservice) review, the Plan will make a decision and notify the Member in writing of its resolution.

For Prospective (preservice) Review Grievances: the Plan will notify the Member or their Authorized Representative and any Practitioners and/or Providers involved in the appeal of the decision in writing or electronically within *thirty (30)* calendar days of receipt of Grievance.

For Retrospective (postservice) Review Grievances: the Plan will notify the Member or their Authorized Representative and any Practitioners and/or Providers involved in the appeal of the decision in writing or electronically within *sixty (60)* calendar days of receipt of Grievance. Member notification of the Grievance response will be logged for reference.

If the 1st Level Grievance Review determination is adverse, the Member shall be informed of the following additional rights:

- a. To request an Additional Voluntary (2nd level) review. Within *five (5)* working days after receipt of the request for a 2nd level review, the Plan will send notice to the Member or an Authorized Representative their rights and responsibilities to participate in the review panel; or
- b. To contact the SD Division of Insurance at:

SD Dept. of Revenue & Regulation
Division of Insurance
445 East Capitol Avenue
Pierre, SD 57501-3185
Fax: (605) 773-5369
Phone: (605) 773-3563
- c. Upon completion of the Plan's Grievance Procedures, to file a civil suit in a court of competent jurisdiction; or
- d. To initiate the external review process for Adverse Determinations based on medical necessity. Refer to the "INDEPENDENT, EXTERNAL REVIEW OF FINAL DETERMINATIONS" Section below for details on this process.

Expedited Grievance Procedure

An expedited Grievance procedure is used when the condition is an emergency or urgent in nature, as defined by the Benefits Policy and in this Policy.

An expedited review involving Urgent Care Requests for Adverse Determinations of **prospective (preservice) or Concurrent Reviews** must be utilized if the Member or Practitioner and/or Provider 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 and/or Provider of care. A designated Physician advisor not involved in the initial Adverse Determination will conduct the review and will be available to discuss the case with the attending Practitioner and/or Provider 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 and the Practitioners and/or 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, Practitioner and those Providers involved in the appeal will receive written notification within *three (3)* calendar days of the telephone notification.

If the expedited review process does not resolve a difference of opinion, the Member or representative may request an Additional Voluntary (2nd level) review. Sanford Health Plan will review this request as a retrospective Grievance.

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.

Additional Voluntary (2nd Level) Review

If a Member requests an additional voluntary (2nd level) review within *five (5)* working days after the date of receipt of the notice, the Plan will notify the Member in writing of their right to:

- (a) Request the opportunity to appear in person before the review panel;
- (b) Receive, upon request, copies of documents and records relevant to the request for benefits;
- (c) Present the Member's case to the review panel;
- (d) Submit written comments, documents, records relevant to the request for benefits to the panel for consideration when conducting the review;
- (e) Ask questions of the review panel; and
- (f) Be assisted or represented by an individual of the Member's choice.

The review panel shall schedule and hold a review meeting within *forty five (45)* working days after the date of receipt of the request. The review meeting shall be held during regular office hours or at the Member's request, can be held via conference call. If the Plan chooses to have an attorney present, the Member shall be notified at least *fifteen (15)* days prior to the meeting and that the Member may wish to obtain legal representation also. If the Member does not request to appeal before the panel, the review panel will issue a decision and notify the Member in writing of the decision within *forty five (45)* working days after the earlier of:

- (a) the date of the request not to appear before the panel, or
- (b) the date that the Member's opportunity to request to appear before the review panel expires.

In conducting the review, the review panel shall take into consideration all comments, documents, records and other information regarding the request for benefits submitted by the Member or Member's authorized representative without regard to whether the information was submitted or considered in the 1st level review.

The majority of members on the review panel shall be comprised of individuals who were not involved in the first level review decision and be health care professionals who have appropriate expertise. A person involved in the 1st level review may be involved in the review panel if a majority of the rest of the panel members were not involved in the 1st level review.

The review panel shall issue a written decision within *five (5)* working days of completing the review meeting. The written decision shall include:

- The titles and qualifying credentials of the panel;
- A statement of the panel's understanding of the nature of the appeal;
- The rationale for the panel's decision;
- Reference to evidence or documentation considered by the panel;
- If applicable, instructions for requesting a written statement on the clinical rationale; and
- Notice of the Member's right to contact the Division of Insurance for assistance including phone number and address.

The decision of the Plan's panel is legally binding on the Plan.

Written Notification Process for Grievances

The written decision for the Grievance reviews will 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 and copies of all documents, records and other information relevant to the Member's benefit request;
5. Statement of the reviewer's understanding of the Member's Grievance;
6. The Reviewer's decision in clear terms and the contract basis or medical rationale in sufficient detail for the Member to respond further;
7. Notification and instructions on how the Practitioner and/or Provider can contact the Physician or appropriate behavioral health (for behavioral health reviews) to discuss the determination;
8. If the Adverse Determination is based on a medical necessity or Experimental or Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of The Plan to the Member's medical circumstances or a statement that an explanation will be provided to the Member free of charge upon request;
9. If applicable, instructions for requesting:
 - (i) A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Determination, as provided in subsection (d) of this section; or
 - (ii) The written statement of the scientific or clinical rationale for the determination, as provided in subsection (e) of this section;
10. For Adverse Determinations of **prospective (preservice) or retrospective (postservice) review** a statement indicating:
 - a) A description of the process to obtain an additional voluntary (2nd level) review of the first level review decision involving an Adverse Determination;
 - b) The written procedures governing the voluntary review, including any required time frame for the review; and
 - c) The Member's right to bring a civil action in a court of competent jurisdiction;
11. If a determination is adverse, the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state insurance director." and the right to bring a civil action in a court of competent jurisdiction;
12. Notice of the Member's right to contact the Division of Insurance for assistance at any time at:

SD Dept. of Revenue & Regulation	Phone: (605) 773-3563
Division of Insurance	Fax: (605) 773-5369
445 East Capitol Avenue	
Pierre, SD 57501-3185	
13. Notice of the right to initiate the External Review process for Adverse Determinations based on medical necessity. Refer to "Independent, External Review Of Final Determinations" in this Section for details on this 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.
14. If the Adverse Determination is completely overturned, the decision notice must state the decision and the date.

Independent, External Review of Final Determinations

South Dakota Independent, External Review Requirements are only available to *medical necessity* adverse determinations.

In the state of South Dakota, where state laws relating to independent, external appeals do not exist, the Plan will follow the procedure for providing independent, external review of final determinations as outlined by the National Committee on Quality Assurance (NCQA).

With the Member's permission, the Plan may refer an appeal directly to an independent review organization without conducting an internal review.

For independent, external review of a final Adverse Determination, the Plan will provide:

1. Members the right to an independent, third party, binding review whenever they meet the following eligibility criteria:
 - a. The Member is appealing an Adverse Determination that is based on medical necessity (benefits Adverse Determinations are not eligible);
 - b. The Member has not appealed to the State of South Dakota;
 - c. Sanford Health Plan has completed one level of internal appeal review and its decision is unfavorable to the Member, or has exceeded the time limit for making a decision, or Sanford Health Plan has elected to bypass the level of appeal with the Member's permission, without good cause and without reaching a decision;
 - d. The total costs related to the entire episode of care or course of treatment prescribed by a Practitioner and/or Provider has exceeded \$500; and
 - e. The request for independent, external review is filed within *one hundred eighty (180)* calendar days of the date that the Plan's Adverse Determination was made.
2. Notification to Members about the independent, external appeal program and decision are as follows:
 - a. General communications to Members, at least annually, to announce the availability of the right to independent, external review.
 - b. Letters informing Members and Practitioners of the upholding of an Adverse Determination covered by this standard including notice of the independent, external appeal rights, directions on how to use the process, contact information for the independent, external review organization, and a statement that the Member does not bear any costs of the independent, external review organization.
 - c. The external review organization will communicate its decision in clear terms in writing to the Member and the Plan. The decision will include the medical necessity rationale and the time frame for implementation, list of titles and qualifications, including specialty, of individuals participating in the appeal review, statement of the reviewer's understanding of the pertinent facts of the appeal and reference to evidence or documentation used as a basis for the decision and, in cases of an Adverse Determination, instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used.
 - d. The external review organization must also notify the Member how and when Members receive any payment or service in the case of overturned Adverse Determinations.
3. Conduct of the appeal program as follows:
 - a. Sanford Health Plan contracts with the independent, external review organization that:
 - i. Conducts a thorough review in which it considers all previously determined facts, allows the introduction of new information, considers and assesses sound medical evidence, and makes a decision that is not bound by the decisions or conclusions of the internal appeal.
 - ii. Completes their review and issues a final decision for non-urgent appeals within *thirty (30)* calendar days of the request. For clinically urgent appeals the review and decision will take *three (3)* calendar days, with the possibility of extending to *five (5)* days for good cause. The organization or the treating Physician may identify a clinically urgent appeal.
 - iii. Has no material professional, familial or financial conflict of interest with Sanford Health Plan.
 - iv. Engages adequate numbers of actively participating Practitioners with the appropriate level and type of clinical knowledge and experience to adjudicate appeals;
 - v. Bases its review on sound clinical evidence, referencing peer-review literature, medical technology assessments and the individual patient record;
 - vi. Carefully protects Member identity, medical record and case information from any unnecessary disclosure;
 - vii. Has effective systems in place to manage the many administrative aspects of appeals, such as tracking cases and accessing legal and medical documents. Provides staff with education and skills training that is required to produce sound, high-quality results.
 - b. With the exception of exercising its rights as party to the appeal, Sanford Health Plan must not attempt to interfere with the independent, external review organization's proceeding or appeal decision.

- c. Sanford Health Plan will provide the independent external review organization with all relevant medical records as allowed by state law, supporting documentation used to render the decision pertaining to the Member's case (summary description of applicable issues including the Plan's decision, criteria used and clinical reasons, UM criteria, communication from the Member to the Plan regarding the appeal), and any new information related to the case that has become available since the internal appeal decision.
 - d. **The Member is not required to bear costs of the independent, external review organization, including any filing fees. However, the Plan is not responsible for costs associated with a hired attorney or traveling to an independent, external review hearing.**
 - e. The Member or his/her legal guardian may designate in writing a representative to act on his /her behalf. A Practitioner and/or Provider may not file an appeal without explicit, written designation by the Member.
 - f. The independent, external review organization's decision is final and binding to the Plan and the Plan implements the independent, external review organization's decision within the time frame specified by the independent, external review organization. The decision is not binding to the Member, because the Member's have legal rights to further pursue appeals in court if they are dissatisfied with the outcome.
4. Sanford Health Plan obtains from the independent, external review organization, or maintains and tracks, data on each appeal case, including descriptions of the denied item(s), reasons for denial, independent, external review organization decisions and reasons for decisions. Sanford Health Plan uses this information in tracking and evaluating its medical necessity decision-making process and improving the quality of its clinical decision making procedures. This information is reported to the Physician Quality Committee when a case is resolved for discussion and plan of care or action.