Notice of Grievance Procedures
Utah Code Annotated §31A-22-629
State of Utah

Quality Control
P.O. Box 82657
Lincoln, NE 68501-2657
877-897-4328 (Toll-Free)

Please read this notice carefully. This notice contains important information about how to file grievances with us. You also have the right to ask us to assist you in filing a grievance, review our decisions involving your requests for benefits, or your requests to have your claims paid.

I. Definitions

"Adverse Benefit Determination" means the denial of a benefit, reduction of a benefit, termination of a benefit or failure to provide or make payment, in whole or in part, for a benefit. "Adverse benefit determination" includes:

a) denial, reduction, termination, or failure to provide or make payment that is based on a determination of an insured's or a beneficiary's eligibility to participate in a plan;

b) with respect to individual or group health plans, and a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for, a benefit resulting from the application of a utilization review; and

c) failure to cover an item or service for which benefits are otherwise provided because it is determined to be:

(i) experimental;
(ii) investigational; or
(iii) not medically necessary or appropriate.

"Medical Necessity" means health care services or products that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (1) in accordance with generally accepted standards of medical practice in the United States; (2) clinically appropriate in terms of type, frequency, extent, site, and duration; (3) not primarily for the convenience of the patient, physician, or other health care provider; and (4) covered under the contract.

"Grievance" means a written complaint on behalf of an insured person submitted by an insured person or their designated representative regarding claims payment, handling, or reimbursement for health care services, including a grievance concerning an adverse benefit determination.

"Designated Representative" means a person, including the treating provider or a person to whom the Covered Person has given express written consent to represent the Covered Person or a person authorized by law to provide substituted consent for a Covered Person, including but not limited to a guardian, agent under a power of attorney, or a proxy.

II. Levels of Review

The following levels of review will be available to a covered person and/or their designated representative.

Internal Reviews - for written grievances, including those resulting from an adverse benefit determination.

Expedited Reviews – for cases involving urgent care claims

Voluntary Independent Review – for resolution of adverse benefit determinations of medical necessity.

A. Internal Reviews

You may send us additional information to support your appeal. You may request copies of any non-privileged information related to your appeal and we will provide it at no charge. You may request the names of any experts we may have consulted who provided advice to us about your claim. If you request any clinical rationale and/or specific clinical guidelines used in the benefit determinations, we will provide them at no charge. If you have a question about diagnosis, you may need to discuss it with your provider, as diagnostic codes are not submitted to use for dental or routine vision clams.

If your appeal is about benefit decisions related to clinic or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If your appeal is about benefit decisions related to policy coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

B. Expedited Review for Urgent Care Claims

For urgent care situations, the covered person or their designated representative may request an expedited review. The request may be given orally or in writing. If the request is made orally, we will send written confirmation within 24 hours to the covered person or designated representative acknowledging receipt of the request for an expedited review. Clinical peers who were not involved in the initial adverse determination will provide expedited review of pre-treatment estimates for urgent care. A covered person does not have the right to attend the expedited or to have a representative in attendance at the expedited review, however the covered person is entitled to submit written comments, documents and records relating to the request for review.

All necessary information, including the plan's original benefit determination, will be transmitted between the plan and the covered person or their designated representative by telephone, facsimile or other available similar expeditious method.

We shall make a decision and notify the covered person or their designated representative as expeditiously as the covered person's medical condition requires, but in no event more than seventy-two (72) hours after the review is commenced.

An expedited review is not available for retrospective adverse benefit determinations.

C. Voluntary Independent Review

A Covered Person or their designated representative may request an independent review for the resolution of adverse benefit determinations of a medical necessity. This request is purely voluntary and left to the discretion of the Covered Person. An independent review organization, person, or entity other than the insurer, the plan the plan's fiduciary, the employer, or any employee or agent of any of the above will conduct this review. Independent review organizations shall be designated by the insurer and shall not in any way be owned or controlled by, or exercise control with a health insurance plan, any trade association of health insurance plans and/or health care providers.

The internal review process must be exhausted before requesting independent review unless the insurer and Covered Person mutually agree to waive the internal process. The Covered Person has 180 calendar days from the date of the final internal review decision to request an independent review.

Under this voluntary independent review process, the insurer:

1. waives any right to assert that a Covered Person has failed to exhaust administrative remedies because the Covered Person did not elect to submit a dispute of medical necessity to a voluntary level of appeal provided by the plan;
2. agrees that any statute of limitations or other defense based on timeliness is tolled during the time a voluntary appeal is pending;
3. will allow the Covered Person to submit a dispute of medical necessity to a voluntary level of appeal only after all internal review options have been exhausted;
4. will provide the Covered Person sufficient information relating to the voluntary level of appeal to enable the Covered Person to make an informed decision about whether to submit a dispute of medical necessity to the voluntary level of appeal, including notice that the decision to use a voluntary level of appeal will not effect the claimant's rights to any other benefits under the plan and information about the rules, the right to representation and the process for selecting the decision maker.

An independent review can be binding on both parties.

You may contact the Utah Insurance Department if you have a question or concern regarding your coverage under this contract. The Department may be contacted:

In Writing:	Utah Insurance Department 3110 State Office Building Salt Lake City, UT 84114-6901
By phone:	801-538-3800

III. Written Decision

When a decision is issued from any level of review, the following information will be included in the written decision:

1. the names, titles and qualifying credentials of the persons participating in the grievance review process;

2. a statement of the reviewer's understanding of the grievance;

3. the decision stated in clear terms and the contract basis or medical rationale supporting the decision, a reference to the evidence or documentation used as a basis for the decision;

4. a description of the health coverage plan's review procedures and the time limits applicable to such procedures and advising the covered person and their designated representative of the right to appeal such decision;

5. a description of any additional material or information necessary, if any, for the covered person and their designated representative to perfect the request for benefits and an explanation of why such material or information is necessary;

6. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, provide the covered person and their designated representative with either the specific rule, guideline, protocol, or other similar criterion or a statement that such rule, guideline, protocol, or other criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the covered person and their designated representative upon request;

7. if the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, furnish the covered person and their designated representative with either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the covered person's medical circumstances, or a statement that such explanation will be provided

free of charge upon request.

8. for internal reviews, a description of the process to obtain a voluntary independent review and the time frame for review.

9. notice of the covered person's right to contact the Utah Insurance Department.