

## **Utilization Review and Grievance Procedures State of Missouri**

### **Introduction**

DSM USA Insurance Company, Inc. (the “Company”) has established procedures to allow you to file grievances with the Company and seek a review of the Company’s decision with respect to grievances. This document describes the Company’s grievance procedures that are available to you. This document is attached to and forms part of your policy or subscriber certificate.

You also have the right to file an appeal with the Director of the Missouri Department of Insurance, Finance and Professional Registration (DIFP) at any time. For detailed information on filing an appeal with the Missouri Department of Insurance, Finance and Professional Registration (DIFP) contact: Missouri Department of Insurance, Finance and Professional Registration (DIFP), ATTN: Consumer Affairs, PO Box 690, Jefferson City, MO 65102. The consumer hot line is 1-800-726-7390.

All grievances and requests for review submitted to the Company pursuant to these Grievance Procedures should be submitted to:

DentaQuest, Grievances and Complaints Department  
P.O. Box 2906  
Milwaukee, WI 53201-2906  
Phone: 1-844-241-5603

### **Definitions**

The following definitions apply to these Grievance Procedures:

***Adverse determination:*** a determination by the Company or its designee utilization review organization that a health care service has been reviewed and, based upon the information provided, does not meet the Company’s requirements for medical necessity or appropriateness and the payment for the requested service is therefore denied, reduced or terminated.

***Concurrent review*** means utilization review conducted during a patient's course of treatment.

***Enrollee*** means a policyholder, subscriber, or other covered individual under a policy or subscriber certificate issued by the Company.

***Grievance*** means a written complaint submitted by or on behalf of an enrollee regarding: (1) the availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; (2) claims payment, handling, or matters pertaining to the contractual relationship between an enrollee and the Company; or (3) matters pertaining to the contractual relationship between an enrollee and the Company.

***Retrospective review*** means utilization review of medical necessity that is conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

***Utilization review*** means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of coverage.

## **Initial Utilization Review Decisions**

### **Proposed Services**

With regard to proposed procedures or services requiring a review determination, the Company shall make initial determinations within 36 hours, which shall include 1 working day, of obtaining all necessary information.

In the case of a determination to certify a procedure or service, the Company shall notify the provider rendering the service by telephone or electronically within 24 hours of making the initial certification, and provide written or electronic confirmation of a telephone or electronic notification to the enrollee and the provider within 2 working days of making the initial certification.

In the case of an adverse determination, the Company shall notify the provider rendering the service by telephone or electronically within 24 hours of making the adverse determination and shall provide written or electronic confirmation of a telephone or electronic notification to the enrollee and the provider within 1 working day of making the adverse determination.

### **Concurrent Reviews**

For concurrent review determinations, the Company shall make the determination within 1 working day of obtaining all necessary information.

In the case of a determination to certify additional services, the Company shall notify by telephone or electronically the provider rendering the service within 1 working day of making the certification, and provide written or electronic confirmation to the enrollee and the provider within 1 working day after telephone or electronic notification. The written notification shall include the next review date, the new total number of days or services approved, and the date of initiation of services.

In the case of an adverse determination, the Company shall notify by telephone or electronically the provider rendering the service within 24 hours of making the adverse determination, and provide written or electronic notification to the enrollee and the provider within 1 working day of

a telephone or electronic notification. The service shall be continued without liability to the enrollee until the enrollee has been notified of the determination.

### Retrospective Reviews

For retrospective review determinations, the Company shall make the determination within 30 working days of receiving all necessary information. The Company shall provide notice in writing of the Company's determination to an enrollee within 10 working days of making the determination.

A written notification of an adverse determination shall include the principal reason or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. The Company shall provide the clinical rationale in writing for an adverse determination, including the clinical review criteria used to make that determination, to any party who received notice of the adverse determination and who requests such information.

### Retraction of Authorization

If an authorized representative of the Company authorizes the provision of health care services, the Company shall not subsequently retract its authorization after the health care services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless (1) such authorization is based on a material misrepresentation or omission about the treated person's health condition or the cause of the health condition; or (2) the policy terminates before the health care services are provided; or (3) the covered person's coverage under the policy terminates before the health care services are provided.

### Levels of Review

**First Level** - A request for a first-level grievance review shall be made within 180 days of the date notice was sent to you informing you of the adverse determination or other decision giving rise to the grievance. Any grievance should be accompanied by documents or records in support of the grievance.

The Company will acknowledge receipt in writing within 10 working days and will investigate the grievance within 20 working days after receipt of a grievance. If additional time is needed to complete the investigation, the Company will notify the enrollee in writing on or before the 20<sup>th</sup> working day with the investigation completed within 30 working days thereafter. The notice shall set forth with specificity the reasons for which additional time is needed for the investigation. The Company will notify the enrollee in writing of the decision within 5 working days following completion of the investigation. The notice will include the right to file an appeal for a second-level review and explain the resolution of the grievance. Within 15 working days after the investigation is completed, the Company will notify the person who submitted the

grievance (if other than an enrollee who already received notice) of the Company's resolution of the grievance.

**Second Level** - You have the right to request a second-level review. A request for a second-level grievance review shall be made within 180 days of the date notice was sent to you informing you of the Company's resolution of the first-level grievance.

Upon receipt of a request for second-level review, the Company will submit the grievance to a grievance advisory panel. Review by the grievance advisory panel shall follow the same time frames as a first-level review, except in the case of a grievance involving a situation where the time frame of the standard grievance procedures would seriously jeopardize the life or health of an enrollee or would jeopardize the enrollee's ability to regain maximum function. Any decision of the grievance advisory panel shall include notice of the enrollee's or the health carrier's or plan sponsor's rights to file an appeal with the director's office of the grievance advisory panel's decision. The notice shall contain the toll-free telephone number and address of the director's office.

### **Expedited Review**

If the time frame of the standard grievance procedures would seriously jeopardize the life or health of an enrollee, an expedited review may be requested. A request for an expedited review may be submitted orally or in writing. However, the request shall not be considered a grievance unless the request is submitted in writing. The Company will notify an enrollee orally within 72 hours after receiving a request for an expedited review of our determination. The Company will provide written confirmation of our decision covering an expedited review within 3 working days of providing notification of the determination.

### **Reconsideration**

A treating provider has the opportunity to request, on behalf of an enrollee, reconsideration of an adverse determination. The reconsideration shall occur within 1 working day of the receipt of the request and shall be conducted between the provider rendering the service and the reviewer who made the adverse determination or a clinical peer designated by the reviewer if the reviewer who made the adverse determination is not available within 1 working day. If the reconsideration process does not resolve the difference of opinion, the adverse determination may be appealed by the enrollee or the provider on behalf of the enrollee. Reconsideration is not a prerequisite to a standard appeal or an expedited appeal of an adverse determination.