

Minnesota Department of Health
Compliance Monitoring Division
Managed Care Systems Section



Final Report

Sanford Health Plan

Quality Assurance Examination
For the period:
July 1, 2007 through June 30, 2010

Final Issue Date:
March 30, 2011

Examiners:
Susan Margot, M.A.
Elaine Johnson, RN, BS, CPHQ

Minnesota Department of Health Executive Summary:

The Minnesota Department of Health (MDH) conducted a Quality Assurance Examination of Sanford Health Plan (Sanford) to determine whether it is operating in accordance with Minnesota law. MDH has found that Sanford is compliant with Minnesota and Federal law, except in the areas outlined in the “Deficiencies” and “Mandatory Improvements” sections of this report. “Mandatory Improvements” are required corrections that must be made to noncompliant policies, documents or procedures where evidence of actual compliance is found in relevant files or where the file sample did not include any instances of the specific issue of concern. The “Recommendations” listed are areas where, although compliant with law, MDH identified improvement opportunities.

To address recommendations, Sanford should:

Revise its policy/procedure to more clearly describe the quality of care complaint resolution process, including the role of USD Patient Relations; the process for review for non-Sanford providers and should define the levels of severity and the range of actions it may take with regard to issues of quality of care and service.

Include screen prints of provider complaint/quality issues from its credentialing system in the file review to demonstrate ongoing monitoring of practitioner complaints and quality issues between recredentialing cycles used in the recredentialing process.

Develop a policy/procedure for supervision and coordination of (restricted) enrollee care.

To address mandatory improvements, Sanford must:

Make the following revisions to its *Minnesota Member Complaint and Appeal Procedures*:

- Remove “Pre-Service Claim,” or prior approval of services from the complaint system policy/procedure.
- State that it will inform the complainant in advance of an extension of the 30-day complaint resolution period and the reasons for the extension.

Revise the policy/procedure, *After Hours and Urgent/Emergent Care Coverage*, to include the factors the physician reviewer must consider before denying a claim for emergency services.

Revise its enrollee continuity of care notice letter, *Sanford Clinic Provider - Left Network*, to include all the conditions under which Sanford is required to continue care and revise the Provider Manual and the policy/procedure (and the provider contract) to be consistent in the timeframe for notice of termination.

When an expedited initial determination is made not to certify, Sanford must notify the enrollee and the attending health care professional of the right to submit an appeal to the expedited

internal appeal and the procedure for initiating both verbally and in writing and add this to its policy.

To address deficiencies, Sanford and its delegates must:

Revise its practices to ensure that enrollee complaints and appeals as described in Minnesota Statutes, sections 62Q.68 through .72 and 62M.06, are correctly categorized and to ensure that dissatisfied enrollees are offered their correct and complete rights.

Ensure that enrollees covered by Sanford Health Plan of Minnesota are notified of the right to file a complaint with the Minnesota Department of Health.

Notify the complainant of the right to external review and the procedure, if the appeal decision is partially or wholly adverse to the complainant.

This report including these deficiencies, mandatory improvements and recommendations is approved and adopted by the Minnesota Commissioner of Health pursuant to authority in Minnesota Statutes, chapter 62D.

Darcy Miner, Director
Compliance Monitoring Division

Date

Table of Contents

I. Introduction	5
II. Quality Program Administration.....	6
Minnesota Rules, Part 4685.1110. Program	6
Minnesota Rules, Part 4685.1115. Activities.....	8
Minnesota Rules, Part 4685.1120. Quality Evaluation Steps	8
Minnesota Rules, Part 4685.1125. Focused Study Steps.....	8
Minnesota Rules, Part 4685.1130. Filed Written Plan and Work Plan.....	8
III. Complaint System.....	8
Minnesota Statutes, Section 62Q.69. Complaint Resolution.....	9
Minnesota Statutes, Section 62Q.70. Appeal of the Complaint Decision.....	10
Minnesota Statutes, Section 62Q.71. Notice to Enrollees	10
Minnesota Rules, Part 4685.1900. Records of Complaints	10
Minnesota Statutes, Section 62Q.73. External Review of Adverse Determinations	10
IV. Access and Availability	11
Minnesota Statutes, Section 62D.124. Geographic Accessibility.....	11
Minnesota Rules, Part 4685.1010. Availability and Accessibility.....	11
Minnesota Statutes, Section 62Q.55. Emergency Services	11
Minnesota Statutes, Section 62Q.121. Licensure of Medical Directors	12
Minnesota Statutes, Section 62Q.527. Coverage of Nonformulary Drugs for Mental Illness and Emotional Disturbance.....	12
Minnesota Statutes, Section 62Q.535. Coverage for Court-Ordered Mental Health Services.....	12
Minnesota Statutes, Section 62Q.56. Continuity of Care	12
V. Utilization Review	13
Minnesota Statutes, Section 62M.04. Standards for Utilization Review Performance.....	13
Minnesota Statutes, Section 62M.05. Procedures for Review Determination	13
Minnesota Statutes, Section 62M.06. Appeals of Determinations not to Certify	14
Minnesota Statutes, Section 62M.08. Confidentiality	15
Minnesota Statutes, Section 62M.09. Staff and Program Qualifications.....	15
Minnesota Statutes, Section 62M.10. Accessibility and on-site Review Procedures	15
Minnesota Statutes, Section 62M.11. Complaints to Commerce or Health.....	15
Minnesota Statutes, Section 62M.12. Prohibition on Inappropriate Incentives.....	15
Minnesota Statutes, Section 62D.12. Prohibited Practices	15
VII. Recommendations	16
VIII. Mandatory Improvements.....	16
IX. Deficiencies	17

I. Introduction

A. History:

Sanford Health Plan is a not-for-profit, community-based HMO that began operations on January 1, 1998. Managed care services are provided to large and small groups in South Dakota, in Iowa and, in Minnesota, by Sanford Health Plan of Minnesota. Originally called Sioux Valley Health Plan, it changed its name in March 2007 to acknowledge the gift of Denny T. Sanford to the Sioux Valley Hospital & Health System.

Sanford's Minnesota HMO is a risk-bearing product that provides benefits for in-network services with higher cost sharing for out-of-network services. Extensive care management services are available.

In November 2009, Sanford Health Plan's parent organization Sanford Health merged with Fargo, ND-based MeritCare, launching a new organization: Sanford Health-MeritCare, now called Sanford Health. Sanford Health Plan of Minnesota is currently licensed in 13 southwest Minnesota counties. For Minnesota, Sanford Health Plan has outlined a service area expansion to align Sanford Health Plan's service area with the newly merged Sanford-MeritCare provider region.

- B. Membership: Sanford's self-reported Minnesota enrollment as of December 31, 2009 consisted of the following:

Product	Enrollment
<i>Fully insured Commercial</i>	
Large Group	305
Small Employer Group	85
Individual	0
Total	390

- C. Onsite Examination Dates: September 20-23, 2010

- D. Examination Period: July 1, 2007 through June 30, 2010

File Review Period: July 1, 2009 to June 30, 2010 or 3 years, as needed to assure an adequate sample of files

- E. Sampling Methodology: Due to the small sample sizes and the methodology used for sample selection for the quality assurance examination, the results cannot be extrapolated as an overall deficiency rate for the health plan.

1. Performance Standard: For each instance of non-compliance with applicable law or rule identified during the course of the quality assurance examination, which covers a three-year audit period, the health plan is cited with a deficiency. A deficiency will not be based solely on one outlier file if MDH had sufficient evidence obtained through: 1) file

review; 2) policies and procedures; and 3) interviews that a plan's overall operation is compliant with an applicable law.

II. Quality Program Administration

Minnesota Rules, Part 4685.1110. Program

Subp. 1.	Written Quality Assurance Plan	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 2.	Documentation of Responsibility	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 3.	Appointed Entity	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 4.	Physician Participation	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 5.	Staff Resources	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 6.	Delegated Activities	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 7.	Information System	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 8.	Program Evaluation	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 9.	Complaints	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 10.	Utilization Review	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 11.	Provider Selection and Credentialing	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 12.	Qualifications	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 13.	Medical Records	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met

Subp. 6. Minnesota Rules, part 4685.1110, subpart 6, states the HMO must develop and implement review and reporting requirements to assure that the delegated entity performs all delegated activities. The standards established by the National Committee for Quality Assurance (NCQA) for delegation are considered the community standard and, as such, were used for the purposes of this examination. The following delegated entities and functions were reviewed:

Delegated Entities and Functions								
	UM	UM Appeals	QM	Complaints/ Grievances	Cred	Claims	Network	Care Coord
Heartland					X			
Meritcare					X			
Express Scripts (ESI)	Approvals					X	X	

Sanford Health Plan does thorough oversight of its delegated entities and functions.

Subd. 9. Minnesota Rules, part 4685.1110, subpart 9, states the quality program must conduct ongoing evaluation of enrollee complaints related to quality of care. Sanford had no quality of care complaints from Minnesota residents during the exam period. MDH reviewed two non-Minnesota resident quality of care complaints to verify implementation of its policy. Credentialing policy, *Monitoring Policy*, PR24, states any complaints relating to quality of actual medical care are reviewed by the Medical Director and “if the complaint represents evidence of poor quality issues that could affect the health and safety of our members or if the practitioner has had five or more complaints on the same type of issue, the practitioner’s file would be taken

to the next Credentialing Committee meeting for review rather than the next recredentialing date.” If an allegation is made regarding a Sanford practitioner, the complaint is “routed to Patient Relations at Sanford USD Medical Center for review and assistance in investigation and determination of a resolution.” The policy is silent as to Patient Relations’ procedures. Sanford acknowledgement letters tell the enrollee to contact a specific individual in Patient Relations, but no notes regarding the investigation or resolution are included in the Sanford files reviewed. Sanford’s policy/procedure should more clearly describe the quality of care complaint resolution process, including the role of USD Patient Relations; the process for review for non-Sanford providers and should define the levels of severity and the range of actions it may take with regard to issues of quality of care and service. **(Recommendation #1)**

Subp. 11. Minnesota Rules, part 4685.1110, subpart 11, states that the health plan must have procedures for credentialing and recredentialing providers that are, at a minimum, consistent with accepted community standards. MDH understands the community standard to be NCQA credentialing and recredentialing standards. MDH reviewed a total of 91 credentialing and recredentialing files (including physician and allied providers) from Sanford and its delegates as follows:

Credentialing and Recredentialing File Review			
File Source	# Reviewed Cred	#Reviewed Recred	# Reviewed Organizational
Sanford	14	16	16
Heartland	11	12	NA
Meritcare	10	12	NA
Total	35	40	16

In the recredentialing process, the health plan is to do ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles to use in the recredentialing process. The Sanford files reviewed contained no documentation that provider complaints and quality issues were reviewed in the recredentialing process. However, that information is collected in the credentialing system Sanford uses. MDH reviewed the system and the information is there. Sanford may want to include screen prints of provider complaint/quality documentation from its system to include in the file review. **(Recommendation #2)**

A requirement of the recredentialing of organizational providers is to confirm that the provider is in good standing with state and federal regulatory bodies. Of the 16 organizational provider files, 15 did not have confirmation that the providers were in good standing with regulatory bodies. Sanford discovered in May 2010 that they were not checking state and federal sanction reports for organizational providers. This was corrected in May 2010. MDH reviewed another six organizational recredentialing files from June and July of 2010. All six files had documentation that the providers were in good standing with state and federal regulatory bodies. MDH commends Sanford for detecting and correcting this issue prior to opening this examination.

Minnesota Rules, Part 4685.1115. Activities

- Subp. 1. Ongoing Quality Evaluation Met Not Met
- Subp. 2. Scope Met Not Met

Minnesota Rules, Part 4685.1120. Quality Evaluation Steps

- Subp. 1. Problem Identification Met Not Met
- Subp. 2. Problem Selection Met Not Met
- Subp. 3. Corrective Action Met Not Met
- Subp. 4. Evaluation of Corrective Action Met Not Met

Minnesota Rules, Part 4685.1125. Focused Study Steps

- Subp. 1. Focused Studies Met Not Met
- Subp. 2. Topic Identification and Selection Met Not Met
- Subp. 3. Study Met Not Met
- Subp. 4. Corrective Action Met Not Met
- Subp. 5. Other Studies Met Not Met

Minnesota Rules, Part 4685.1130. Filed Written Plan and Work Plan

- Subp. 1. Written Plan Met Not Met
- Subp. 2. Work Plan Met Not Met

MDH commends Sanford for its comprehensive and detailed annual work plan.

III. Complaint System

MDH examined Sanford’s fully-insured commercial complaint system under Minnesota Statutes, chapter 62Q.

MDH reviewed a total of 21 Sanford Complaint System files. The sample included all complaints and non-clinical appeal files for the three year exam period:

Complaint System File Review	
Complaint and Appeal File Source	# Reviewed
<i>Complaint Files (Oral and Written)</i> [All]	2
<i>Non-Clinical Appeal Files</i> [All]	19
Total	21

Minnesota Statutes, Section 62Q.69. Complaint Resolution

Subd. 1.	Establishment	<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met
Subd. 2.	Procedures for filing a complaint	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 3.	Notification of Complaint Decisions	<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met

Subd. 1. Minnesota Statutes, section 62Q.69, subdivision 1, states the plan must establish and maintain an internal complaint resolution process that provides for the resolution of a complaint.

The law provides for a sequential process for resolution of oral and written complaints, followed by an appeals process. Consequently, it is difficult to understand how the number of non-clinical appeals (as noted in the table above) could exceed the number of complaints, since a non-clinical appeal must first be reviewed as a complaint. Sanford practices regarding categories of complaints and clinical and non-clinical appeals does not maintain a process consistent with Minnesota law or their own written policies/procedures. In file review, MDH found a number of issues related to miss-categorized complaints and appeals as defined in Minnesota Statutes, sections 62Q.68 and.70:

- Notes in two “non-clinical appeal” files indicated previous oral contact that was not listed in the oral complaint file lists. Sanford stated that enrollees frequently called to request information. These calls are classified as “inquiries” (not reviewed by MDH). Sanford didn’t ascertain the enrollee’s dissatisfaction. As a result, the enrollee was not offered a written complaint form and wasn’t offered assistance.
- Of 19 non-clinical appeal files reviewed, six were actually written complaints as defined by Minnesota Statutes, section 62Q.68, subdivision 2. After a written complaint, the enrollee has an appeal available, as defined in Minnesota Statutes, section 62Q.70. Because the complaint was processed as an appeal rather than a complaint, the enrollee lost the right to appeal.
- Three “non-clinical appeal” files were actually medical information submitted in support of a previous denial. Medical information provided in support of a previous denial should be identified as a clinical appeal and be reviewed by the medical review staff consistent with Minnesota Statutes, section 62M.06.

(Deficiency #1)

Subd.1. Sanford provided policy/procedure, *Minnesota Member Complaint and Appeal Procedures*. The following policy/procedure provisions are not compliant with Minnesota law:

- Minnesota Statutes, section 62Q.68, subdivision 2, defines Complaint as a grievance against the plan. The Sanford policy/procedure, *Minnesota Member Complaint and Appeal Procedures*, includes procedures for written complaints, appeals and “pre-service claims” (or prior authorizations). Under *Formal/Written Complaint Process*, item b, the policy/procedure gives direction *For Pre-Service Claims*, or prior approval of services. Pre-service claims or prior authorizations are a utilization management function governed by Minnesota Statutes, chapter 62M. Pre-service claims are not a part of the complaint

system. Sanford must revise its *Minnesota Member Complaint and Appeal Procedures* to address the complaint system as governed by Minnesota Statutes, chapter 62Q.

- Minnesota Statutes, section 62Q.69, subdivision 3(a), states, if the plan takes additional days beyond the initial 30-day period to resolve a complaint, it must inform the complainant in advance of the extension and the reasons for the extension. Sanford's policy/procedure does not include this requirement.

(Mandatory Improvement #1)

Subd. 3(c). Minnesota Statutes, section 62Q.69, subdivision 3(c), states the notification of the complaint determination must include the right to submit the complaint at any time to the Minnesota Commissioner of Health. In two files, the enrollee was offered the right to submit a complaint to South Dakota's commissioner. **(Deficiency #2)**

Minnesota Statutes, Section 62Q.70. Appeal of the Complaint Decision

Subd. 1.	Establishment	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 2.	Procedures for Filing an Appeal	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 3.	Notification of Appeal Decisions	<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met

Subd. 3(b). Minnesota Statutes, section 62Q.70, subdivision 3(b), states, if the decision is partially or wholly adverse to the complainant, the notice must advise the complainant of the right to external review and the procedure. Two "non-clinical appeal" files upheld the original claim denial. Sanford offered a voluntary second level of review, but did not offer external review. **(Deficiency #3)** [Also see Minnesota Statutes, sections 62Q.73, subdivision 3 and 62M.06, subdivision 3(g)]

Minnesota Statutes, Section 62Q.71. Notice to Enrollees

Met Not Met

Minnesota Rules, Part 4685.1900. Records of Complaints

Subp. 1.	Record Requirements	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subp. 2.	Log of Complaints	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met

Minnesota Statutes, Section 62Q.73. External Review of Adverse Determinations

Subd. 3.	Right to external review	<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met
----------	--------------------------	------------------------------	---

(Deficiency #3) [See Minnesota Statutes, sections 62Q.70, subdivision 3(b) and 62M.06, subdivision 3(g)]

IV. Access and Availability

Minnesota Statutes, Section 62D.124. Geographic Accessibility

- | | | | |
|----------|---|---|----------------------------------|
| Subd. 1. | Primary Care; Mental Health Services; General Hospital Services | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 2. | Other Health Services | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 3. | Exception | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |

Minnesota Rules, Part 4685.1010. Availability and Accessibility

- | | | | |
|----------|---------------------------------------|---|----------------------------------|
| Subp. 2. | Basic Services | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subp. 5. | Coordination of Care | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subp. 6. | Timely Access to Health Care Services | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |

Subp. 5A(2). Minnesota Rules, part 4685.1010, subpart 5A(2), states, if requested or determined necessary because of a pattern of inappropriate utilization of services, an enrollee's health care may be supervised and coordinated by the primary care provider. Sanford has restricted enrollees to particular providers due to inappropriate utilization; however Sanford does not have a policy/procedure for the process. To ensure consistent and fair application of a restriction, Sanford should develop a policy/procedure for supervision and coordination of enrollee care. **(Recommendation #3)**

Minnesota Statutes, Section 62Q.55. Emergency Services

Met Not Met

Minnesota Statutes, section 62Q.55, states in reviewing a denial of emergency services, the plan must consider:

- (1) a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next working day or next available clinic appointment;
 - (2) the time of day and day of the week the care was provided;
 - (3) the presenting symptoms, including, but not limited to, severe pain, to ensure that the decision to reimburse the emergency care is not made solely on the basis of the actual diagnosis;
- In addition, emergency care which would have been covered had notice been provided within the set time frame must be covered.

Sanford's policy, MM46, *After Hours and Urgent/Emergent Care Coverage*, states emergency claims are not automatically denied. A physician reviews the case for presenting symptoms prior to making an approval or denial decision. In practice, Sanford Health Plan does not deny any emergency services on the basis of medical necessity. However, the policy/procedure must include all the factors the physician reviewer must consider. **(Mandatory Improvement #2)**

Minnesota Statutes, Section 62Q.121. Licensure of Medical Directors

Met Not Met

Minnesota Statutes, Section 62Q.527. Coverage of Nonformulary Drugs for Mental Illness and Emotional Disturbance

- Subd. 2. Required Coverage for Anti-psychotic Drugs Met Not Met
- Subd. 3. Continuing Care Met Not Met
- Subd. 4. Exception to formulary Met Not Met

Minnesota Statutes, Section 62Q.535. Coverage for Court-Ordered Mental Health Services

- Subd. 1. Mental health services Met Not Met
- Subd. 2. Coverage required Met Not Met

Minnesota Statutes, Section 62Q.56. Continuity of Care

- Subd. 1. Change in health care provider; general notification Met Not Met
- Subd. 1a. Change in health care provider; termination not for cause Met Not Met
- Subd. 1b. Change in health care provider; termination for cause Met Not Met
- Subd. 2. Change in health plans Met Not Met
- Subd. 2a. Limitations Met Not Met
- Subd. 2b. Request for authorization Met Not Met
- Subd. 3. Disclosures Met Not Met

Subd. 1a(b). Minnesota Statutes, section 62Q.56, subdivision 1a(b), states that if a provider terminates not for cause, enrollees must be notified of their rights to continue care with the terminated provider. Upon request, the plan must authorize up to 120 days with the current provider if the enrollee is engaged in a current course of treatment for the following conditions:

- (1) (i) an acute condition;
(ii) a life-threatening mental or physical illness;
(iii) pregnancy beyond the first trimester of pregnancy;
(iv) a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or
(v) a disabling or chronic condition that is in an acute phase; or
- (2) or the rest of the enrollee's life if a physician certifies that the enrollee has an expected lifetime of 180 days or less.

Sanford provided its plan in policies/procedures, MM-31 *Continuity and Coordination of Care*; PR-07 *Practitioner Termination*; and MM-44 *Transition of Care*. The large group Certificate of Coverage is correct. Sanford’s plan is good, with the following concerns:

- The letter, *Sanford Clinic Provider - Left Network*, does not include the conditions under which Sanford is required to continue care. The letter must be revised to state all the circumstances specified by law under which the plan is required to continue care with the terminated provider.
- In addition, *Provider Termination* states “In Minnesota, the practitioner or facility must give Sanford Health Plan 120 days’ notice.” The Internet based Provider Manual states all provider voluntary terminations must be made in writing to Sanford 60 days prior to the effective termination date. The Provider Manual and the policy/procedure (and the provider contract) must be consistent in the timeframe for notice of termination.
(Mandatory Improvement #3)

V. Utilization Review

UM System File Review		
File Source		# Reviewed
<i>UM Denial Files</i>	[ALL]	19
<i>Clinical Appeal Files</i>	[ALL]	8
	Total	27

Minnesota Statutes, Section 62M.04. Standards for Utilization Review Performance

- Subd. 1. Responsibility on Obtaining Certification Met Not Met
- Subd. 2. Information upon which Utilization Review is Conducted Met Not Met
- Subd. 3. Data Elements Met Not Met
- Subd. 4. Additional Information Met Not Met
- Subd. 5. Sharing of Information Met Not Met

Minnesota Statutes, Section 62M.05. Procedures for Review Determination

- Subd. 1. Written Procedures Met Not Met
- Subd. 2. Concurrent Review Met Not Met
- Subd. 3. Notification of Determinations Met Not Met
- Subd. 3a. Standard Review Determination
- (a) Initial determination to certify (10 business days) Met Not Met
- (b) Initial determination to certify (telephone notification) Met Not Met
- (c) Initial determination not to certify Met Not Met

(d) Initial determination not to certify (notice of rights to external appeal)

		<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 3b.	Expedited Review Determination	<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met
Subd. 4.	Failure to Provide Necessary Information	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 5.	Notifications to Claims Administrator	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met

Subd. 3b. Minnesota Statutes, section 62M.05, subdivision 3b, states when an expedited initial determination is made not to certify, the HMO must also notify the enrollee and the attending health care professional of the right to submit an appeal to the expedited internal appeal and the procedure for initiating. One UM denial file contained a request for an expedited authorization that was denied. Documentation of the verbal notification did not contain the right to submit an expedited appeal. The notification letter stated the member could appeal but did not state the right to expedited appeal. Expedited appeal was included in the *Minnesota Member Complaint and Appeal Procedures* that accompanied the notification letter. The policy entitled *Medical Management Program* did not include that the HMO must notify the enrollee and the attending health care professional of the right to submit an expedited appeal. Sanford must notify the enrollee of the right to an expedited appeal verbally and in writing and must add this to the policy. **(Mandatory Improvement #4)**

Minnesota Statutes, Section 62M.06. Appeals of Determinations not to Certify

Subd. 1.	Procedures for Appeal	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 2.	Expedited Appeal	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
Subd. 3.	Standard Appeal		
	(a) Appeal resolution notice timeline	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
	(b) Documentation requirements	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
	(c) Review by a different physician	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
	(d) Time limit in which to appeal	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
	(e) Unsuccessful appeal to reverse determination	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
	(f) Same or similar specialty review	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met
	(g) Notice of rights to External Review	<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met
Subd. 4.	Notifications to Claims Administrator	<input checked="" type="checkbox"/> Met	<input type="checkbox"/> Not Met

Subd. 3(c). Minnesota Statutes, 62M.06, subdivision 3(c), states that prior to upholding the initial determination not to certify for clinical reasons, the HMO shall conduct a review of the documentation by a physician who did not make the initial determination not to certify. In the seven appeal files where the denial was overturned on appeal, the Medical Director did both the initial denial and overturned the denial upon appeal, which is appropriate. In the notification letter, it states that the physician reviewer “was not involved in the initial decision”. This is an inaccurate statement. Sanford found this error in February 2009 and corrected the letter template. MDH reviewed an additional five appeal files done in August through December of 2009 and the notification letters in all five files were correct. MDH commends Sanford for detecting and correcting this issue prior to the opening of this examination.

Subd. 3(g). Minnesota Statutes, section 62M.06, subdivision 3(g), states if the initial

determination is not reversed on appeal, the plan must include in its notification the right to submit the appeal to external review and the procedure. In two post-service appeal files, Sanford upheld its initial determination based on the investigational nature of the service. Sanford sent the resolution letter and appeal rights notice to the enrollee. The letter directed the enrollee to the appeal rights section for a voluntary second level of appeal, but did not refer the enrollee to external review. **(Deficiency #3)** [Also see Minnesota Statutes, sections 62Q.70 and 62Q.73, subdivision 3]

Minnesota Statutes, Section 62M.08. Confidentiality

Met Not Met

Minnesota Statutes, Section 62M.09. Staff and Program Qualifications

- | | | | |
|-----------|--|---|----------------------------------|
| Subd. 1. | Staff Criteria | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 2. | Licensure Requirement | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 3. | Physician Reviewer Involvement | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 3a. | Mental Health and Substance Abuse Review | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 4. | Dentist Plan Reviews | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 4a. | Chiropractic Reviews | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 5. | Written Clinical Criteria | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 6. | Physician Consultants | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 7. | Training for Program Staff | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 8. | Quality Assessment Program | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |

Minnesota Statutes, Section 62M.10. Accessibility and on-site Review Procedures

- | | | | |
|----------|--------------------------------------|---|----------------------------------|
| Subd. 1. | Toll-free Number | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 2. | Reviews during Normal Business Hours | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
| Subd. 7. | Availability of Criteria | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |

Minnesota Statutes, Section 62M.11. Complaints to Commerce or Health

Met Not Met

Minnesota Statutes, Section 62M.12. Prohibition on Inappropriate Incentives

Met Not Met

Minnesota Statutes, Section 62D.12. Prohibited Practices

- | | | | |
|-----------|---------------------|---|----------------------------------|
| Subd. 19. | Coverage of service | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met |
|-----------|---------------------|---|----------------------------------|

VII. Recommendations

1. To better comply with Minnesota Rules, part 4685.1110, subpart 9, Sanford should revise its policy/procedure to more clearly describe the quality of care complaint resolution process, including the role of USD Patient Relations; the process for review for non-Sanford providers; and should define the levels of severity and the range of actions it may take with regard to issues of quality of care and service.
2. To better comply with Minnesota Rules, part 4685.1110, subpart 11, Sanford should include screen prints of provider complaint/quality issues from its credentialing system in the file review to demonstrate ongoing monitoring of practitioner complaints and quality issues between recredentialing cycles used in the recredentialing process.
3. To better comply with Minnesota Rules, part 4685.1010, subpart 5A(2), Sanford should develop a policy/procedure for supervision and coordination of (restricted) enrollee care.

VIII. Mandatory Improvements

1. To comply with Minnesota Statutes, section 62Q.69, subdivision 1, Sanford must make the following document revisions:
 - Revise its policy/procedure, *Minnesota Member Complaint and Appeal Procedures*, to remove “Pre-Service Claim,” or prior authorization of services from the complaint system policy/procedure.
 - Revise its policy/procedure, *Minnesota Member Complaint and Appeal Procedures*, to state that it will inform the complainant in advance of an extension of the 30-day complaint resolution period and the reasons for the extension.
2. To comply with Minnesota Statutes, section 62Q.55, must revise the policy/procedure, *After Hours and Urgent/Emergent Care Coverage*, to include all the factors the physician reviewer must consider before denying a claim for emergency services.
3. To comply with Minnesota Statutes, section 62Q.56, subdivision 1a(b), Sanford must
 - Revise its enrollee notice letter, *Sanford Clinic Provider - Left Network*, to include all the conditions under which Sanford is required to continue care.
 - Revise the Provider Manual and the policy/procedure (and the provider contract) to be consistent in the timeframe for notice of termination.
4. To comply with Minnesota Statutes, section 62M.05, subdivision 3b, when an expedited initial determination is made not to certify, Sanford must notify the enrollee and the attending health care professional of the right to submit an appeal to the expedited internal

appeal and the procedure for initiating both verbally and in writing and add this to its *Medical Management Program* policy.

IX. Deficiencies

1. To comply with Minnesota Statutes, section 62Q.69, subdivision 1, Sanford must revise its practices to ensure that enrollee complaints and appeals as described in Minnesota Statutes, sections 62Q.68 through .72 and 62M.06, are correctly categorized and to ensure that dissatisfied enrollees are offered their correct and complete rights.
2. To comply with Minnesota Statutes, section 62Q.69, subdivision 3(c), Sanford must ensure that enrollees covered by Sanford Health Plan of Minnesota are notified of the right to file a complaint with the Minnesota Department of Health.
3. To comply with Minnesota Statutes, sections 62Q.70, subdivision 3(b); 62Q.73, subdivision 3; and 62M.06, subdivision 3(g); Sanford must notify the complainant of the right to external review and the procedure if the appeal decision is partially or wholly adverse to the complainant.