Grievance Form

Sutter Health Plan

If you have encountered any difficulties or have had any concerns with Sutter Health Plan or a Sutter Health Plan provider, please give us a chance to help. You have up to 180 calendar days from the date of the incident that caused your dissatisfaction to submit a grievance.

Note: You are not required to use this form to file a grievance or complaint. If you prefer, you may call Sutter Health Plan Customer Service at 855-315-5800 (TTY 855-830-3500) to file your complaint or grievance.

If you wish to use this form to start the grievance process, fill out the form below. Describe the situation in detail, including the specific details of the problem, such as where and when it happened, and what you believe we can do to resolve the concern.

Member Name

Sutter Health Plan ID#

Date of Birth

Mailing Address

City

State

ZIP

Phone #

Email Address

Name of Person Filing the Grievance & Relationship (if other than member)

Best Way To Reach You

Best Hours

Details of your complaint: (Please be as specific as possible with dates, times and the nature of the problem. Include the names, if any, of anyone in Sutter Health Plan or the provider office with whom you discussed this. Use the other side of this form or additional sheets if you need more room.)

If you have received a denial for treatment, services or supplies deemed experimental and have an incurable or irreversible condition that has a high probability of causing death within one year or less (terminal illness), and you would like to request a conference as part of the grievance system, please place a check mark in the space below.

☐ Yes, I have a terminal illness and am requesting a conference.

Signature

Date

Sutter Health Plan

Please send your completed Grievance Form to:

MAIL
Sutter Health Plan
Attn: Appeals & Grievances Department
P.O. Box 160305
Sacramento, CA 95816

FAX
916-736-5422
(Toll-Free 855-759-8755)

You can also submit a grievance by:

TELEPHONE
Customer Service
855-315-5800
(TTY 855-830-3500)

ONLINE
Through your Member Portal account at
shplan.org/memberportal (registration required)

Note: If this case involves an imminent and serious threat to the member, including but not limited to severe pain or the potential loss of life, limb or major bodily function, please call Customer Service at 855-315-5800 (TTY 855-830-3500) to file your complaint or grievance. You may also call the California Department of Managed Health Care at 888-466-2219 (TDD 877-688-9891).

Notice to the Member or Your Representative

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-855-315-5800 (TTY 1-855-830-3500)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Grievance Process Overview

Policy

Sutter Health Plan established a formal grievance process because we want members to be satisfied with their healthcare. The formal grievance process addresses member concerns, complaints, appeals or requests to review a coverage decision. This process provides members with fair treatment of their grievance and a prompt response that complies with all required standards.

Sutter Health Plan handles all member information confidentially in compliance with Sutter Health Plan policies and procedures as well as applicable laws and regulations. Sutter Health Plan does not and will not discriminate against any member who has filed a grievance.

Sutter Health Plan will ensure that all members have access to and can fully participate in the grievance system by helping those with limited English proficiency or with visual or other communicative impairments. Such assistance will include but is not limited to translation of grievance procedures, forms and plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that help individuals with disabilities communicate.

Definition of a Grievance

A grievance is a written or oral expression of dissatisfaction regarding the plan and/or provider, including but not limited to concerns with quality of care, quality of service and access to care, and will include a complaint, dispute, request for reconsideration or appeal made by a member or the member's representative.

When Sutter Health Plan is unable to distinguish between a grievance and an inquiry, it will be considered a grievance.

Members have up to 180 calendar days from the date of the incident that caused the member's dissatisfaction to submit a grievance to Sutter Health Plan.

File a Grievance

A member may file a grievance or have a representative file a grievance. A member may appoint any individual (such as a relative, friend, advocate, attorney or physician) to act as the member's representative and file a grievance on their behalf. Members must appoint a representative in writing. Also, a representative may be authorized by a court to act in accordance with State law to file a grievance for a member.

Members can file a grievance by contacting Customer Service toll-free at:

Sutter Health Plan
855-315-5800
(TTY 855-830-3500)

A trained Customer Service representative will try to answer questions or resolve the concerns and issues expressed during the call. If the Customer Service representative cannot resolve the situation, ask the representative for more information about how to file a grievance.

- If preferred, members may mail a grievance or submit the Grievance Form in writing to:

  Sutter Health Plan
  Attn: Appeals & Grievances Department
  P.O. Box 160305
  Sacramento, CA 95816

  Fax: 916-736-5422 (Toll-Free 855-759-8755)

  Please include detailed information about the questions or situation, the reasons for dissatisfaction, and the desired resolution. If members want help filing a grievance, call Customer Service, and a representative will help complete the Grievance Form or explain how to write the letter. They will also be happy to take the information over the phone.
- Members can fill out a grievance form available at the provider's office.
- Members can submit the Grievance Form online at **shplan.org/memberportal** (registration required).

Please tell us if this case involves an imminent and serious threat to the member, including but not limited to severe pain or the potential loss of life, limb or major bodily function.

Grievances Related to Mental Health and Substance Use Disorders

U.S. Behavioral Health Plan, California (USBHPC) administers all levels of review under the Sutter Health Plan Grievance Process for complaints regarding mental health and substance use disorder services. If a member has an inquiry or concern regarding mental health or substance use disorder benefits, the member should first call the USBHPC Member Services Department at 855-202-0984. USBHPC makes every effort to resolve member inquiries or concerns through their Member Services Department.

Members may submit a written or verbal grievance to USBHPC Grievance Unit at:

USBHPC
Attn: Appeals & Grievances Department
P.O. Box 30512
Salt Lake City, UT 84130

Online: **liveandworkwell.com**
Telephone: 855-202-0984

Grievance forms and filing information are available through the USBHPC Member Services Department.

Standard Grievance Review

Sutter Health Plan will send an acknowledgment letter to the member within five calendar days of receipt of a standard grievance. We will fully investigate the grievance, including all aspects of medical care involved. If the grievance involves a quality of care, quality of service or access to care issue, or involves medical decision-making, it is reviewed by the Sutter Health Plan Care Management Department, under the direction of the Medical Director of Care Management.

For standard grievances, a determination is made and the outcome is sent in writing to the member within 30 calendar days from our receipt of the grievance. The grievance outcome letter will include an explanation of the rationale for the decision.

Expedited Grievance Review

The grievance system includes an expedited review process for urgent grievances. A grievance is expedited when a delay in decision-making would pose an imminent and serious threat to the health of the member, including but not limited to potential loss of life, limb or major bodily function. If the grievance qualifies for an expedited review, a member may request expedited review by contacting Customer Service or by filing a complaint with the California Department of Managed Health Care (DMHC) (see next section, "Further Appeal Rights").

The Expedited Grievance process is initiated using one of the methods listed under “File a Grievance.” Calling Customer Service is the recommended method for requesting an expedited review.

Upon receipt of a grievance, we log the grievance and collect all necessary information in order to review and make a decision. After an appropriate clinical peer reviewer has reviewed all of the information and determined the case qualifies for expedited review, a written disposition is sent to the member and any applicable providers within three calendar days from our receipt of the grievance. The letter contains all rationale used in making the decision.

If a member makes a request for an expedited review and it is determined that the grievance does not qualify for an expedited review, Sutter Health Plan will review the grievance in the standard 30-day grievance process. Sutter Health Plan will notify the member by mail if the grievance does not qualify for expedited review.

Further Appeal Rights

Members may be able to pursue one or more of the following appeal processes, depending on the situation. Members can contact Customer Service for help determining appeal rights.

1. File a complaint with the DMHC.

   The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-855-315-5800 (TTY 1-855-830-3500)** and use your health plan’s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR).

   If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department’s internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

2. Request Independent Medical Review.

   The independent medical review (IMR) process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. Sutter Health Plan must provide you with an IMR application form with any grievance disposition letter that denies, modifies, or delays health care services.

A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against the plan regarding the disputed health care service.

Eligibility

(a) Disputed Health Care Service. You may request an IMR of disputed health care services from the DMHC if you believe that health care services have been improperly denied, modified, or delayed by Sutter Health Plan or one of its contracting providers. A "Disputed Health Care Service" is any health care service eligible for coverage and payment under your subscriber contract that has been denied, modified, or delayed by Sutter Health Plan or one of its delegates, in whole or part on findings that the proposed services were not medically necessary. Your application for IMR will be reviewed by the DMHC to confirm that the conditions of eligibility set forth below are satisfied:

i. The member's provider has recommended a health care service as medically necessary, OR the member has received an urgent care or emergency service that a provider determined was medically necessary, OR the member, in the absence of such a recommendation or the receipt of urgent care or emergency services, has been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which the member seeks independent review.

ii. The Disputed Health Care Service has been denied, modified, or delayed by Sutter Health Plan or its delegated entity, based in whole or in part, on a decision that it is not medically necessary.

iii. The member filed a grievance with Sutter Health Plan or its delegate and the disputed decision is upheld or the grievance remains unresolved past 30 days. If your grievance requires expedited review, you may bring it immediately to the DMHC's attention. The DMHC may waive the requirement that you follow the Sutter Health Plan grievance process in extraordinary and compelling cases.

iv. You apply for an IMR within six months after Sutter Health Plan sends you a written response to your grievance, unless the DMHC determines that circumstances prevented timely submission.

(b) Investigational/Experimental Treatment. Sutter Health Plan excludes from coverage services, medication or procedures which are considered investigational and/or experimental treatments, and which are not accepted as standard medical practice for the treatment of a condition or illness. You may request an IMR from DMHC if Sutter Health Plan or its delegate denies a treatment, service or supply on the basis that it is experimental or investigational. Your application for IMR will be reviewed by the DMHC to confirm the conditions of eligibility set forth below are satisfied:

i. The member has a Life-threatening or Seriously Debilitating Condition. "Life-threatening" means either a disease or condition where the likelihood of death is high unless the course of the disease is interrupted, or a disease or condition with potentially fatal outcomes, where the end point of clinical intervention is survival. "Seriously Debilitating" means a disease or condition that causes major irreversible morbidity.

ii. The member's physician has certified that standard therapies are or have not been effective in improving the member's condition, or would not be medically appropriate for the member, or there is no more beneficial standard therapy covered by Sutter Health Plan than the therapy proposed for the member.

iii. Either the member's physician, contracted with Sutter Health Plan, who has recommended the denied course of treatment that he/she certified in writing is likely to be more beneficial to the member than any available standard therapies, will include a statement of the evidence relied upon in his/her recommendation; or the member, or his/her physician who is a licensed, board-certified or board-eligible physician not contracted with Sutter Health Plan, but qualified to practice in the specialty appropriate to treat the member's condition, has requested a therapy that, based on two documents from the medical and scientific evidence, is likely to be more beneficial for the member than any available standard therapy.

iv. The member has been denied coverage by Sutter Health Plan for a drug, device, procedure, or other therapy recommended or requested pursuant to paragraph (b)(iii) above.

v. The specified denied therapy is one that would be a covered service, except for the Sutter Health Plan determination that the therapy is experimental or investigational for the given condition.

Process

To request an IMR, you may call the DMHC's toll-free telephone number (888-466-2219) or a TDD line (877-688-9891) for the hearing and speech impaired, or obtain IMR application forms and instructions online at the DMHC's website **www.dmhc.ca.gov.**

The DMHC will review your application and send you a letter within seven days telling you if you qualify for IMR. If your case is eligible for IMR, when all your information, including relevant medical records, is received by DMHC, the dispute will be submitted to a medical specialist at a review agency who will make an independent determination of whether or not the care is medically necessary.

Sutter Health Plan will gather all medical records and necessary documentation relevant to the member's condition and will forward all information to the review agency within three business days from the date we receive notice from the DMHC of the IMR request for standard requests, or within one calendar day for an expedited IMR.

You will receive a copy of the assessment made in your case. If the IMR determines the service is medically necessary, Sutter Health Plan will provide coverage for the health care service.

For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within 30 calendar days of receipt of your application and supporting documentation. For urgent cases involving an Expedited Grievance, the IMR organization must provide its determination within three calendar days.

3. Binding Arbitration

If you continue to be dissatisfied with the results of the grievance process and wish to pursue the matter further, you must submit your claim or controversy to binding arbitration within 60 days of completion of the grievance process. The arbitration procedure is governed by the American Arbitration Association rules. Copies of these rules and other forms and information about arbitration are available by calling the American Arbitration Association at 800-778-7879 or visiting the website at **adr.org**.

All interested parties, including members, specifically agree to use Sutter Health Plan arbitration procedure in place of any rights they otherwise would have to submit any controversy or dispute to a court or jury. For a complete description of how to initiate arbitration, please refer to your subscriber agreement.