

AN ACT

ENTITLED, An Act to revise the requirements for utilization review and grievance procedures.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

Section 1. That § 58-17C-94 be amended to read as follows:

58-17C-94. With respect to a voluntary review of a first level review decision made pursuant to §§ 58-17C-83 to 58-17C-86, inclusive, a health carrier shall appoint a review panel to review the request. 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 covered person or the covered person's authorized representative pursuant to § 58-17C-93, without regard to whether the information was submitted or considered in reaching the first level review decision. The decision of the panel is legally binding on the health carrier.

Except for an individual who was involved with the first level review decision who may be a member of the panel or appear before the panel to present information or answer questions, a majority of the panel shall be comprised of individuals who were not involved in the first level review decision made pursuant to §§ 58-17C-83 to 58-17C-86, inclusive.

The health carrier shall ensure that a majority of the individuals conducting the additional voluntary review of the first level review decision made pursuant to §§ 58-17C-83 to 58-17C-86, inclusive, are health care professionals who have appropriate expertise. If a reviewing health care professional without the expertise required by this section is not reasonably available and there has been a denial of a health care service, the reviewing health care professional is only ineligible to review decisions if the professional meets both of the following criteria:

- (1) The professional is a provider in the covered person's health benefit plan; and
- (2) The professional has financial interest in the outcome of the review.

Section 2. That § 58-17C-100 be amended to read as follows:

58-17C-100. In an expedited review that is not an initial determination for benefits, all necessary information, including the health carrier's decision, shall be transmitted between the health carrier and the covered person or, if applicable, the covered person's authorized representative by telephone, facsimile, or the most expeditious method available.

Section 3. That § 58-17C-101 be amended to read as follows:

58-17C-101. An expedited review decision, that is not an initial determination for benefits, shall be made and the covered person or, if applicable, the covered person's authorized representative shall be notified of the decision in accordance with § 58-17C-102 as expeditiously as the covered person's medical condition requires, but in no event more than seventy-two hours after the date of receipt of the request for the expedited review. If the expedited review is of a grievance involving an adverse determination with respect to a concurrent review urgent care request, the service shall be continued without liability to the covered person until the covered person has been notified of the determination.

For purposes of calculating the time periods within which a decision is required to be made under this section, the time period within which the decision is required to be made shall begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures established pursuant to § 58-17C-82 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

Section 4. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

The provisions of §§ 58-17C-40 to 58-17C-102, inclusive, do not apply to any medicare supplement policies or certificates subject to the provisions of chapter 58-17A.

Section 5. That § 58-17C-3 be amended to read as follows:

58-17C-3. Nothing in § 58-17C-2 applies to dental only, vision only, accident only, school

accident, travel, or specified disease plans or plans that primarily provide a fixed daily, fixed occurrence, or fixed per procedure benefit without regard to expenses incurred.

An Act to revise the requirements for utilization review and grievance procedures.

=====
I certify that the attached Act
originated in the
HOUSE as Bill No. 1051

\_\_\_\_\_  
Chief Clerk

\_\_\_\_\_  
Speaker of the House

Attest:

\_\_\_\_\_  
Chief Clerk

\_\_\_\_\_  
President of the Senate

Attest:

\_\_\_\_\_  
Secretary of the Senate

House Bill No. 1051  
File No. \_\_\_\_\_  
Chapter No. \_\_\_\_\_

=====
Received at this Executive Office
this \_\_\_\_ day of \_\_\_\_\_ ,
20\_\_ at \_\_\_\_\_ M.

By \_\_\_\_\_  
for the Governor

=====
The attached Act is hereby
approved this \_\_\_\_\_ day of
\_\_\_\_\_, A.D., 20\_\_

\_\_\_\_\_  
Governor

=====
STATE OF SOUTH DAKOTA,
ss.
Office of the Secretary of State

Filed \_\_\_\_\_, 20\_\_
at \_\_\_\_\_ o'clock \_\_ M.

\_\_\_\_\_  
Secretary of State

By \_\_\_\_\_  
Asst. Secretary of State