HEALTH PLAN POLICY		
Policy Title: Provider Complaints and Appeals		**Policy Number:** OPCGA17 **Revision:** G
Department: Operations	**Sub-Department:** Complaints, Grievances and Appeals	
Applies to Product Lines: ☒Medicaid ☒Children's Health Insurance Plan ☒Health Insurance Exchange ☐Medicare		☐USFHP ☒Commercial Insured ☐Non Insured Business
Origination/Effective Date: 07/16/2015		
Reviewed Date(s):	**Revision Date(s):** 12/01/2016, 09/28/2017, 02/27/2019, 03/25/2020, 03/23/2021, 03/01/2022, 04/12/2023	

SCOPE:

This policy applies to all CHIP, Health Insurance Exchange, and STAR Medicaid provider complaints and appeals.

DEFINITIONS AND ACRONYMS:

- **Adverse Determination – A** determination by an MCO or Utilization Review agent that the health care services furnished, or proposed to be furnished to a patient, are not medically necessary or not appropriate.
- **Appeal –** The formal process by which a Provider request a review of the MCO's Action.
- **Complainant** – A member, an individual acting on behalf of a member, or a member's provider of record, who initiates the complaint process.
- **Complaint –** Any dissatisfaction, expressed by a complainant, orally or in writing to the MCO, with any aspect of the MCO's operation, including, but not limited to, dissatisfaction with plan administration, procedures related to review or appeal of an adverse determination, as defined in Texas Insurance Code, Chapter 843, Subchapter G; the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions. The term does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the CHIP member.
- **Complaint Acknowledgement Letter –** Written communication mailed to a complainant after receipt of the oral and written complaint request containing a description of the health plan's complaint process and the time frame for resolution of the complaint.
- **Complaint Summary Form** – A one-page form mailed to a Complainant with the Acknowledgement Letter following the receipt of an oral complaint. The form includes a prominent and clear statement that the form must be returned to the health plan for prompt resolution.
- **Covered Person** – The person for whom a request has been made and covered under the medical benefit plan administered through this policy. This term "Covered Person" is meant to be synonymous with "member", "beneficiary", "enrollee", "subscriber", and "patient."
- **Discriminate –** As used in this context, discriminate means treating a member differently from

others in the provision of a covered service or accessibility to a facility on the basis of cost of service, race, color, language, culture, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, type or degree of illness or condition, or physical or mental disability.

- **Expedited Complaint** – A complaint to the health plan in which the decision is required quickly due to the service being related to emergency care, a life-threatening condition, or a denial of continued stay of a hospitalized member.
- **External Review** – The review of an adverse determination by an external review organization that is not affiliated with the health plan and has been approved by the State of Texas.
- **Managed Care Organization (MCO)**
- **Member –** A person who is enrolled in an insured plan and receiving services from the health plan.
- **Member Advocate –** An associate working in the Complaints, Appeals, and Grievances (CAG) Department. Non-clinical CAG Associates do not perform initial screenings or utilization review, including approval of requested health care services. Clinical associates that conduct utilization review must hold an unrestricted license, an administrative license, or be otherwise authorized to provide health care services by a licensing agency in the United States. The member advocate is responsible for resolving all complaints as follows: (1) Within the guidelines and processes established by the health plan; (2) In accordance with the requirements of the Texas Department of Insurance (TDI) and the Texas Health and Human Services Commission (HHSC). The procedures facilitate the evaluation of complaints from each complainant.
- **Person Acting on Behalf of Member (PAB) –** Any person acting on behalf of the member.
- **Physician Peer Reviewer (PPR) –** A Physician of the same or similar specialty who was not involved in the initial determination. The PPR:
  - May not be the subordinate of any person involved in the initial determination.
  - Are not involved in any previous level of review or decision-making, and are health care professionals who have the appropriate clinical expertise in treating the member's condition or disease.
- **Provider –** An appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and subcontractors, that has a contract with the plan for the delivery of Covered Services to the plan Members.
- **Quality of Care Complaint** – A complaint filed by, or on behalf of the health plan member or members, regarding the quality of care rendered by, or professional conduct of a participating practitioner or other provider. These complaints are researched and handled in accordance with the Plan's Peer Review Policy and Procedure.

POLICY:

Providers have the right to file a complaint/appeal with the health plan in writing.

Dissatisfaction involving aspects of the health plan operations including claims payment issues are considered provider complaints/appeals and will be handled in accordance with the Provider Complaint and Appeal Policy.

Provider benefit denial appeals are treated as member appeals and are handled according to the Member Complaint/Appeal Policy.

All provider requests for appeal must be submitted to the health plan within one hundred and eighty (180) calendar days of the initial notification date. The health plan will make every effort to resolve provider complaints/appeals using established and consistent procedures for reviewing and responding no later than 30 calendar days from the date the complaint/appeal was received.

Policies and procedures performed by the health plan and its subcontractors are detailed within this policy. It is the sole responsibility of the health plan to ensure the delegated functions are performed in accordance with applicable federal and state standards. All complaints/appeals are handled in a confidential manner.

The health plan does not discriminate against or take punitive action against a provider for filing a complaint/appeal with the health plan, Texas Health and Human Services Commission (HHSC) or Texas Department of Insurance (TDI).

The health plan notifies providers of the opportunity to receive information regarding the complaint/appeal process.

1. Procedure

The complaint/appeal is received by the health plan and forwarded to the Complaints, Appeals, and Grievances department. The complaint/appeal is then logged and an acknowledgment letter is sent to the provider no later than the fifth business day after the date of receiving the request. The letter acknowledges the complaint/appeal was received and explains to the provider that the complaint/appeal will be resolved within 30 calendar days of receipt. The health plan maintains all provider complaint/appeal logs which includes documentation of each complaint/appeal received and details of the action taken to resolve the issue. Provider complaints/appeals are logged to identify trends or opportunities for improvement.

If the complaint/appeal involves medical necessity determination, it will be forwarded to the Medical Director for review. If the complaint/appeal does not involve medical necessity review, it will be forwarded to the appropriate area within the health plan for review. The health plan will issue a written response to the provider within 30 calendar days that explains the health plan decision, including any medical or contractual reasons, if the complaint/appeal was reviewed by another physician, includes his or her specialty.

CHIP and Health Insurance Exchange providers who have attempted to resolve a complaint/appeal with the health plan and are still dissatisfied with the resolution may submit a complaint with the Texas Department of Insurance (TDI).

STAR providers who have attempted to resolve a complaint/appeal with the health plan and are still dissatisfied with the resolution may submit a complaint with the Texas Health and Human Services Commission (HHSC).

2. Reporting and Record Maintenance

The health plan prepares quarterly reports, tracks and trends provider complaints and appeals, and

presents the report to the Quality Improvement Committee (QIC). The QIC reviews the complaint and appeals to identify and address trends.

The health plan maintains a complaint/appeal log of all complaints and appeals received by the health plan that details the actions taken for each complaint/appeal. The log is available at the time of examination. The log is maintained until the fourth (4^{th}) anniversary of the date the complaint/appeal was received.

The health plan maintains and submits to TDI, upon request, documentation that details the reasonable opportunity discussion with the provider of record, including the date and time the opportunity was offered to discuss the adverse determination, the date and time that discussion, if any, took place, and the discussion outcome.

REFERENCES:

- Texas Administrative Code
- Texas Insurance Code, Chapter 843, Subchapter G
- Texas Health and Human Services Commission (HHSC) Uniform Managed Care Contract, Section 8.2.4.1 Provider Complaints
- HHSC Uniform Managed Care Contract, Section 8.4.1 CHIP Provider Complaints
- Code of Federal Regulations, Title 42, Chapter 4, Subchapter C, Part 438

RELATED DOCUMENTS:

None

REVISION HISTORY:

Revision	Date	Description of Change	Committee
New	07/16/2015	Initial release.	Board of Directors
A	12/01/2016	Yearly review, updated template and signature, added the Health Insurance Exchange LOB to existing policy	Board of Directors
B	09/28/2017	Yearly review. Changed policy name. Updated signatory to reflect CEO.	Board of Directors
C	02/27/2019	Updated P&P to include process for contract and non-contract provider.	Executive Leadership
D	03/25/2020	Yearly review – no change to content.	Executive Leadership
E	03/23/2021	Yearly review – no change to content.	Executive Leadership
F	03/01/2022	Yearly review – no change to content.	Executive Leadership
G	04/12/2023	Annual review. Minor changes made for formatting and grammar.	Executive Leadership