HEALTH PLAN POLICY	
Title: Provider Complaints and Appeals	**Number:** OPCGA17 **Revision:** H
Department: Operations	**Sub-Department:** Complaints, Grievances and Appeals
Applicable Lines of Business: ☐ Children's Health Insurance Plan ☐ Medicare ☒ Commercial Insured ☐ Non-Insured Business ☒ Health Insurance Exchange ☐ USFHP ☐ Medicaid	
Effective Date: 07/16/2015	
Revision Date(s): 12/01/2016, 09/28/2017, 02/27/2019, 03/25/2020, 03/23/2021, 03/01/2022, 04/12/2023, 06/24/2024	

PURPOSE:

This policy applies to any 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 member, do not meet the requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made in whole or in part, for the benefit.
- **Appeal –** A request by a member, Authorized Representative, provider, or supplier for the review and reconsideration of an adverse determination made by the health plan related to health plan items or services.
- **Complainant** – A member, an individual acting on behalf of a member, or a member's provider of record, who initiates the complaint process.
- **Complaint –** An expression of dissatisfaction (other than an organization determination) presented verbally or in writing related to any aspect of the operations, activities, or behavior of a health plan, or its providers, regardless of whether remedial action is requested which expression may involve a grievance, coverage determination, or both. A complaint also may involve a Late Enrollment Penalty (LEP) determination. Every complaint must be handled under the appropriate process.
- **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 –** 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)** – Entities that serve Medicare or Medicaid beneficiaries on a risk basis through a network of employed or affiliated providers.
- **Member –** The individual member, enrollee, or beneficiary eligible and enrolled in a state or federally funded or commercial health care program.
- **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 –** Any individual or entity, acting on behalf of the health plan or its affiliates, that delivers or authorizes the provision of medical or health-related services to a health plan member.
- **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's decision, including any medical or contractual reasons, and 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	Approval 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
H	06/24/2024	Annual review. Updated definitions and formatting.	Executive Leadership