Appeals and Grievance Procedures

1. PURPOSE

1.1 Scott and White Health Plan recognizes that an enrollee, physician, provider, or other person designated to act on behalf of an enrollee may encounter an event in which performance under this agreement does not meet expectations. It is important that such an event be brought to the attention of the Health Plan. The Health Plan is dedicated to addressing problems quickly, managing the delivery of Health Care Services effectively, and preventing future Appeals or Grievances.

1.2 The Medical Director of the Scott and White Health Plan has overall responsibility for the coordination of the Appeal and Grievance procedure. For assistance with this procedure, individuals should contact a Member Relations Coordinator at the Health Plan office.

1.3 The procedures described in this section may be used if you have an Appeal or Grievance that you want to submit to Scott and White Health Plan for review and resolution. These procedures include:

1.3.1 Medicare Standard Appeals Procedure
1.3.2 Medicare Expedited/72-Hour Appeals Procedure
1.3.3 Peer Review Organization (PRO) Immediate Review of Hospital Discharges
1.3.4 The Scott and White Health Plan Grievance Procedure

2. DEFINITIONS

2.1 **Appeal** - Any of the procedures that deal with the review of adverse organization determinations on the health care services a member is entitled to receive or any amounts that the member must pay for a covered service. These procedures include Reconsiderations by the Health Plan, review by an independent review entity, hearings before Administrative Law Judges (of the Social Security Administration), review by the Department Appeals Board (DAB), and judicial review.

2.2 **Grievance** - Any complaint or dispute other than one involving an Organization Determination. Examples of issues that involve a complaint that will be resolved through the Grievance rather than the Appeal process are: waiting times in physician offices; rudeness or unresponsiveness of customer service staff.

2.3 **Peer Review Organization (PRO)** - Groups of health care professionals who are hired by the Federal Government to review medical necessity, appropriateness and quality of medical care and services provided to Medicare beneficiaries. Upon request, the PRO also reviews hospital discharges for appropriateness and quality-of-care complaints.

2.4 **Reconsideration** - Coverage decisions regarding such issues as payment for emergency services, post-stabilization care, urgently needed services, payments to non-contracting medical providers or facilities, and discontinuation of services.

2.5 **Second Level Grievance** - is a request for the Health Plan to reverse a previous decision for a Grievance regarding such issues as quality of services, office waiting times, physician behavior, adequacy of facilities, and involuntary disenrollment.

2.6 **Time-Sensitive** – A situation in which waiting for a standard decision or an authorization for a service could seriously jeopardize your life or health, or your ability to regain maximum function.

3. MEDICARE APPEALS PROCEDURE

3.1 As a Member of Scott and White Health Plan, you have the right to have any decision about our payment for, or failure to arrange or continue to arrange for, what you believe are Covered Services (including non-Medicare covered Benefits) under Health Plan reconsidered. Coverage decisions that are commonly reconsidered include decisions with respect to:

3.1.1 Payment for Emergency Services, Post-Stabilization Care, or Urgently Needed Services;

3.1.2 Payment for any other health services furnished by a Non-Contracting Medical Provider or Facility that you believe should have been arranged for, furnished, or reimbursed by the Health Plan;

3.1.3 Services you have not received, but which you feel the Health Plan is responsible to pay for or arrange; or

3.1.4 Discontinuation of services that you believe are Medically Necessary Covered Services.

3.2 You should use the Health Plan Grievance Procedures (discussed below) for complaints that do not involve coverage decisions such as those set forth. If you have a question about what type of complaint process to use, please call a Scott and White Health Plan Member Relations Coordinator.

3.3 As discussed below, Health Plan has a Standard Determination and Appeal procedure and an expedited determination and Appeal procedure.

3.4 Who May File an Appeal:

3.4.1 You may file an Appeal.

3.4.2 Someone else may file the Appeal for you on your behalf. You may appoint an individual to act as your representative to file the Appeal for you by following the steps below:

3.4.2.1 Give us your name, your Medicare number and a statement, which appoints an individual as your representative. (Note: You may also appoint a physician or a Provider.) For example: I, ___[your name]

appoint [name of representative] to act as my representative in requesting an Appeal from the Scott and White Health Plan and/or the Health Care Financing Administration regarding the denial or discontinuation of medical services.

3.4.2.2 You must sign and date the statement.

3.4.2.3 Your representative must also sign and date this statement unless he/she is an attorney.

3.4.2.4 You must include this signed statement with your Appeal.

3.4.3 A Non-Contracting Physician or other Provider who has furnished you a service may file a standard Appeal of a denied claim if he/she completes a waiver of payment statement, which says he/she will not bill you regardless of the outcome of the Appeal.

3.5 Support for Your Appeal

3.5.1 Scott and White Health Plan is responsible for gathering all necessary medical information relevant to your request for Reconsideration (Appeal). However, it may be helpful to include additional information to clarify or support your request. For example, you may want to include in your Appeal request information such as medical records or physician opinions in support of your request. To obtain medical records, you may send a written request to your Primary Care Physician. If your medical records from a Specialist are not included in your medical record from your Primary Care Physician, you may need to make a separate request to the Specialist who provided medical services to you.

3.5.2 You have the opportunity to provide additional information in person or in writing. In the case of an expedited decision or Appeal, you or your authorized representative may submit evidence, in person, via telephone, or in writing transmitted by fax at the address and telephone number referenced below under the expedited/72-hour review procedure.

4. MEDICARE STANDARD APPEALS PROCEDURE

4.1 In the case of a Standard Determination and Appeal, Health Plan must make a determination (decision) on your request for payment or provision of services within the following time frames:

4.1.1 **Request for Service.** If you request services, or require Prior Authorization of a Referral for services, Health Plan must make a decision as expeditiously as your health requires, but no later than fourteen (14) calendar days after receiving your request for service. An extension of up to fourteen (14) calendar days is permitted, if you request the extension or if we have a need for additional information and the extension of time benefits you. For example, if we need additional medical records from Non-Contracting Medical Providers that could change a denial decision.

4.1.2 **Requests for Payment.** If you request payment for services already received, the Health Plan will make a decision on whether or not to pay the claim no later than sixty (60) calendar days from receiving your request. If the decision is made in your favor, we will make payment within thirty (30) days.

4.2 Health Plan must notify you in writing of any adverse decision (partial or complete) within the time frames listed above. The notice must state the reasons for the denial and also must inform you of your right to Reconsideration as well as the Appeals process. If you have not received such a notice within fourteen (14) calendar days of your request for services, or within sixty (60) days of a request for payment, you may assume the decision is a denial, and you may file for an Appeal.

4.3 If you decide to proceed with the Medicare Standard Appeals Procedure, the following steps will occur:

1. You must submit a written request for Reconsideration to Health Plan at 2401 South 31st Street, Temple, TX 76508. You may also request a Reconsideration through the Social Security office (or, if you are a railroad retirement beneficiary, through a Railroad Retirement Benefits Office). You must submit your written request within sixty (60) calendar days of the date of the notice of the initial decision.

   Note: The sixty (60)-day limit may be extended for good cause. Include in your written request the reason why you could not file within the sixty (60)-day time frame.

2. Health Plan will conduct a Reconsideration and notify you in writing of the decision, using the following time frames:

   Request for Service. If the Appeal is for a denied service, we must notify you of the Reconsideration decision as expeditiously as your health requires, but no later than thirty (30) days from receipt of your request. We may extend this time frame by up

to fourteen (14) days if you request the extension or if we need additional information, and the extension of time benefits you; for example, if we need additional medical records from Non-Contracting Medical Providers that could change a denial decision.

Request for Payment. If the Appeal is for a denied claim, the Health Plan must notify you of the Reconsideration determination no later than sixty (60) days after receiving your request for a Reconsideration determination.

4.4 Our Reconsideration decision will be made by a person(s) not involved in the initial decision. A physician must make all Reconsiderations of determinations based on lack of medical necessity with appropriate expertise in the field of medicine appropriate for the services at issue. During the Reconsideration, you or your authorized representative may present or submit relevant facts and/or additional evidence for review either in person or in writing.

4.4.1 If we decide to uphold the original adverse decision, either in whole or in part, we will automatically forward the entire file to the Center for Health Dispute Resolution (CHDR) for a new and impartial review. CHDR is HCFA's independent contractor for Appeal reviews involving managed care plans, like the Scott and White Health Plan. We must send CHDR the file within thirty (30) days of a request for services and within sixty (60) days of a request for payment. CHDR will either uphold the decision or issue a new decision. If we forward the case to CHDR, we will notify you of our decision as discussed above.

4.4.2 For cases submitted for review, CHDR will make a Reconsideration decision and notify you in writing of their decision and the reasons for the decision. If CHDR upholds our decision, their notice will inform you of your right to a hearing before an administrative law judge of the Social Security Administration. If CHDR decides in your favor, we must provide or authorize the service within thirty (30) days, or make payment within sixty (60) days.

4.4.3 If there is at least $100 in controversy, you may request a hearing before an administrative law judge (ALJ) by submitting a written request with the Health Plan, CHDR or the Social Security Administration withing sixty (60) days of the date of CHDR's notice that the Reconsideration decision was not in your favor. This sixty (60)-day notice may be extended for good cause. All hearing requests will be forwarded to CHDR. CHDR will then forward your request and your Reconsideration file to the hearing office. Health Plan will also be made a party to the Appeal at the ALJ level.

4.4.4 Either you or Health Plan may request a review of an ALJ decision by the Departmental Appeals Board (DAB), which may either review the decision or decline review.

4.4.5 If the amount involved is $1000 or more, either you or Health Plan may request that a decision made by the DAB, or the ALJ if the DAB has declined review, be reviewed by a Federal district court.

4.4.6 Any initial or reconsidered decision made by Health Plan, CHDR, the ALJ, or the DAB can be reopened by any party (a) within twelve months, (b) within four (4) years for just cause, or (c) at any time for clerical correction of an error or in cases of fraud.

4.4.7 The reconsidered determination is final and binding upon Health Plan.

5. MEDICARE EXPEDITED/72-HOUR DETERMINATION AND APPEAL PROCEDURE

5.1 You have the right to request and receive expedited decisions affecting your medical treatment in a Time-Sensitive situation. If Health Plan decides, based on medical criteria, that your situation is Time-Sensitive or if any physician makes the request for you or calls or writes in support of your request for an expedited review, we will issue a decision as expeditiously as your health requires, but no later than seventy-two (72) hours after receiving the request. We may extend this time frame by up to fourteen (14) days if you request the extension or if we need additional information, and the extension of time benefits you; for example, if we need additional medical records from Non-Contracting Medical Providers that could change a denial decision.

5.2 Types of Decisions Subject to Expedited/72-Hour Review

5.2.1 **Expedited Determinations.** If you believe you need a service, or continue to need a service, and you believe it is a Time-Sensitive situation, you or any physician (including a physician with no connection to Scott and White Health Plan) may request that the decision be expedited. If Health Plan decides that it is a Time-Sensitive situation, or if any physician states that it is one, we will make a decision on your request for a service on an expedited/72-hour basis (subject to an extension as discussed above).

5.2.2 **Expedited Appeals.** If you want to request a Reconsideration (Appeal) of a decision to deny a service you requested or to discontinue a service you are receiving that you believe is a Medically Necessary Covered Service and you believe it is a Time-Sensitive situation, you may request that the Appeal be expedited. If a physician wishes to file an expedited Appeal for you, you must give him or her authorization to act on your behalf. If we decide that it is a Time-Sensitive situation, or if any physician states that it is one, we will make a decision on your Appeal on an expedited/72-hour basis (subject to an extension as discussed above).

5.3 How to Request an Expedited/72-Hour Review

5.3.1 To request an expedited/72-hour review, you or your authorized representative may call, write, fax or visit the Scott and White Health Plan. Be sure to ask for an expedited/72-hour review when you make your request.

Call: **1-800-456-7947**

TDD/TDY: **1-254-724-3038**

Write: **Scott and White Health Plan**
ATT: Expedited 72-Hour Review Unit/MRC
2401 South 31st Street
Temple, TX 76508

Fax: **1-254-298-3385**

Walk-in: **Scott and White Health Plan**
2401 South 31st Street
Temple, TX 76508
Hours: 8 am - 5 pm

5.4 How Your Expedited/72-Hour Review Request will be Processed

5.4.1 Upon receiving your Reconsideration request the Health Plan will determine if your request meets the definition of Time-Sensitive.

5.4.1.1 If your request does not meet the definition, it will be handled within the Standard review process. You will be informed by telephone or in person whether your request will be processed through the expedited seventy-two (72) hour review or the standard review process. You will also be sent a written confirmation within two (2) working days of the phone call. If you disagree with the Health Plan's decision to process your request within the standard time frame, you may file a Grievance with Health Plan. The written confirmation letter will include instructions on how to file a Grievance. If your request is Time-Sensitive, you will be notified of our decision as expeditiously as your health requires but no later than seventy-two (72) hours. You will also be sent a follow-up letter within 2 working days of the phone call (subject to extension as described above).

5.4.2 Your request must be processed within seventy-two (72) hours if any physician calls or writes in support of your request for an expedited/72-hour review, and the physician indicates that applying the standard review time frame could seriously jeopardize your life or health or your ability to regain maximum function.

5.4.2.1 If a Non-Contracting Medical Provider supports your request, Health Plan will have seventy-two (72) hours from the time it receives all the necessary medical information from that Provider.

5.4.3 The Health Plan will make a decision on your Appeal and notify you of it within 72-hours of receipt of your request. If we decide to uphold the original decision, either in whole or in part, the entire file will be forwarded by the Health Plan to CHDR for review as expeditiously as your health requires, but no later than 24 hours after our decision. CHDR will send you a letter with their decision within ten (10) working days of receipt of your case from Health Plan.

5.4.4 If you have questions regarding these rights, you may contact a Member Relations Coordinator at 1-800-456-7947.

6. PEER REVIEW ORGANIZATION (PRO) IMMEDIATE REVIEW OF HOSPITAL DISCHARGES

6.1 You have the right to receive all the Hospital care that is necessary for the proper diagnosis and treatment of your illness or injury. According to Federal law, your discharge date must be determined solely by your medical needs. When you are being discharged from the hospital, you may receive a written notice of explanation called a Notice of Non-Coverage. This document outlines your rights, and you do not have to disagree with the non-coverage determination in order to receive it. The hospital is required to issue this notice. You have the right to request a review by a Peer Review Organization (PRO) of any written Notice of Non-Coverage that you receive from Health Plan or from the Hospital on our behalf stating that we will no longer pay for your Hospital care. Such a request must be made by noon of the first workday after you receive the Notice of Non-Coverage. You cannot be made to pay for your Hospital care until the PRO makes its decision.

6.2 PROs are groups of doctors who are paid by the Federal Government to review Medical Necessity, appropriateness, and quality of Hospital treatment furnished to Medicare patients, including those enrolled in the Scott & White Health Plan. The phone number and address of the PRO for your area is:

Texas Medical Foundation
Philip K. Dunne, CEO
901 Mopac Expressway South
Barton Oaks Plaza Two, Suite 200
Austin, TX 78746

6.3 If you ask for immediate review by the PRO by noon on the workday following a Notice of Non-Coverage, you will be entitled to this process instead of the Standard Appeals process that is described in this section. You will also be protected from liability for hospital services until the PRO makes its decision. Instead of PRO review you may Appeal the Notice of Non-Coverage within 60 days as discussed above by requesting that Health Plan reconsider the decision. The advantage of the PRO review is that you will get the results

within three working days if you request the review on time. Also, you are not financially liable for hospital charges during the PRO review process. This same protection does not apply in the case of the Health Plan Reconsideration process.

Note: You may file an oral or written request for an expedited/72-hour Health Plan Appeal only if you have missed the deadline for requesting the PRO review. Specifically state that you have missed the immediate PRO review deadline, you want an expedited Appeal (or 72-hour) and that you believe your health could be seriously harmed by waiting for a standard Appeal.

If you are concerned about the quality of care you have received, you may file a complaint with the Peer Review Organization (PRO) in your local area. (The name, address, and telephone number of your local PRO are referenced in section 6.2 above.)

7. HEALTH PLAN GRIEVANCE PROCEDURES

7.1 As a Scott and White Health Plan Member, you have the right to file a Grievance about problems you observe or experience, including:

7.1.1 Grievances about the quality of services that you receive;

7.1.2 Grievances regarding such issues as office waiting times, physician behavior, adequacy of facilities, or other similar Member concerns;

7.1.3 Involuntary Disenrollment situations;

7.1.4 If you disagree with our decision to process your request for a service or to continue a service under the standard fourteen (14) day time frame rather than the expedited/72 hour time frame;

7.1.5 If you disagree with our decision to process your Appeal request under the standard thirty (30) day time frame rather than the expedited/72 hour time frame.

7.2 Grievances

7.2.1 Health Plan will send an acknowledgment letter of the receipt of oral or written Grievances from you no later than five (5) business days after the date of the receipt of the Grievance. The acknowledgment letter will include a description of the Health Plan's Grievance procedures and time frames. If the Grievance is received orally, the Health Plan will also enclose a one-page Grievance form, which must be returned for prompt resolution of the Grievance.

7.2.2 Health Plan will acknowledge, investigate, and resolve all Grievances within thirty (30) calendar days after the date of receipt of the written Grievance or one-page Grievance form from you. However, investigation and resolution of Grievances concerning emergencies or denials of continued stays for hospitalization shall be concluded in accordance with the immediacy of the case and will not exceed one (1) business day from receipt of the Grievance.

7.2.3 Health Plan will investigate the Grievance and issue a response letter to you within thirty (30) days from receipt of the Grievance explaining the specific medical and/or contractual reasons for the resolution and the specialization of any physician or other provider consulted. The response letter will contain a full description of the process for Second Level Grievance, including the time frames for the Second Level Grievance process and the time frames for the final decision on the Grievance.

8. SECOND LEVEL GRIEVANCE

8.1 If you are not satisfied with the Health Plan's resolution of the Grievance, you will be given the opportunity to appear before a Grievance panel or address a written Grievance to a Grievance panel.

8.2 Health Plan will send an acknowledgment letter of the receipt of oral or written Grievance from you no later than five (5) business days after the date of the receipt of the Grievance. The acknowledgment letter will include a description of the health plan's Second Level Grievance procedures and time frames. If the Second Level Grievance is received orally, the health plan will also enclose a one-page Second Level Grievance form, which must be returned for prompt resolution of the Grievance.

8.3 Health Plan will appoint members to the Grievance panel, which shall advise the Health Plan on the resolution of the Grievance. The Grievance panel shall be composed of equal numbers of Health Plan staff, physicians or other providers, and enrollees. No member of the Grievance panel may have been previously involved in the disputed decision. The physicians or other providers must have experience in the same or similar specialty who typically treats the medical condition, performs the procedure or provides the treatment in the area of care that is in dispute and must be independent of any physician or provider who made any prior determination. If specialty care is in dispute, the Grievance panel must include a person who is a specialist in the field of care to which the Grievance relates. The enrollees may not be employees of the Health Plan.

8.4 No later than five (5) business days before the scheduled meeting of the panel, unless you agree otherwise, the Health Plan will provide to you or your designated representative:

8.4.1 any documentation to be presented to the panel by the Health Plan staff;

8.4.2 the specialization of any physicians or providers consulted during the investigation; and

8.4.3 the name and affiliation of each Health Plan representative on the panel.

8.5 You or your designated representative is entitled to:

8.5.1 appear before the Grievance panel in person or by other appropriate means;

8.5.2 present alternative expert testimony; and

8.5.3 request the presence of and question any person responsible for making the prior determination that resulted in the Grievance.

8.6 Notice of the final decision of the Health Plan on the Grievance will include a statement of the specific contractual criteria used to reach the final decision. The notice will also include the toll-free telephone number and the address of the Texas Department of Insurance.

8.7 Health Plan will complete the Grievance process no later than the thirty (30) calendar days after the date of the receipt of the written request for Grievance or one-page Grievance form from you.