Corporate Procedures

Procedure Name	**Texas - Provider Appeal Process**
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Procedure Owner	Quality
Category	Complaints and Appeals

Approval Date: 08/31/2018

Approved By: Christine Turano

Procedure Overview

Davis Vision has a process in place to respond fully and completely to each Provider's claims payment appeal and establish a tracking mechanism to document the status and final disposition of each Provider's claim payment appeal.

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Scope

This procedure applies to both participating and non-participating providers in the State of Texas for Davis Vision's managed care operations.

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Administration

1. The Complaints & Appeals department is responsible for ensuring this procedure is enforced.
2. Complaints & Appeals may periodically update this procedure. At a minimum, this procedure will be reviewed annually to determine if any updates or changes are needed.
3. This procedure requires the approval of the Corporate Compliance Officer (CCO). The CCO may delegate approval authority.
4. Prior to any changes to this procedure, Complaints & Appeals must review and approve to ensure consistency with required control design and State/Federal compliance.

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Appealed Claim

A claim that has been previously adjudicated as a clean claim and the provider is appealing the disposition through written notification and in accordance with the appeal process. Claim payment appeals may also include retrospective medically necessary reviews.

The provider must have adhered to all filing and appeal deadlines for an appeal as defined in the Provider Manual and noted below.

Provider Dispute Resolution (PDR) Timelines and Practices

Filing Timeframes and Requirements

Provider has 120 days from the date of the notice of denial of payment to request appeal of a claim disposition in writing. If the 120 day appeal deadline falls on a weekend or holiday, the deadline is extended to the next business day.

Providers may request a claim payment appeal by contacting Davis Vision by using a Provider Dispute Resolution Form or submitting a letter via mail or the Davis Vision Web site at **www.davisvision.com**. Written correspondence can be submitted to:

Davis Vision
Quality Assurance Department
P.O. Box 791
Latham, NY 12110

Appeal Practice

An acknowledgement of appeal will be sent to the provider within 5 calendar days summarizing the challenge, requesting additional information, if required, and providing clear direction as to how to submit additional information for review.

We will render a decision and notify the provider in writing within 30 calendar days of the receipt of the appeal.

Additional Appeal Rights

If a provider is not satisfied with the outcome of the review conducted through the Provider Appeal Process, the provider may initiate applicable remedies below:

- Arbitration (handled per the applicable Client and/or Davis Vision Provider Contract)
- If the arbitration processes has been exhausted, and the provider is unsatisfied with the outcome, the provider may file a complaint with (based on line of business):

    - Texas STAR Program (Medicaid) and Child Health Insurance Program (CHIP): Texas Health and Human Services Commission at Managed Care Operations, H320, PO Box 85200, Austin, TX 78708-5200.
    - Commercial Programs: The Texas Department of Insurance (TDI), HMO Quality Assurance Section, Mail Code 103-6A, P.O. Box 149104, Austin, TX 78714-9104

Reporting

All adjudicated provider appealed claims will be tracked and reported upon request pursuant with State regulation and/or client contract. All cases entered into the sub-system shall be categorized for necessary reporting as one or more of the following but not limited to:

- Quality of care or services
- Accessibility/availability of services
- Utilization review or management
- Complaint procedures
- physician and provider contracts
- Group subscriber contracts
- Individual subscriber contracts
- Marketing
- Claims processing
- Miscellaneous

Texas Medicaid Only: Davis Vision will be subject to liquidated damages if at least 98% of provider appeals are not resolved within 30 calendar days of receipt by Davis Vision. Adherence is monitored via internal management reporting to ensure compliance with this standard.

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Record Keeping

Complete files will be maintained for a minimum of ten (10) years in accordance with Davis Vision's record retention policy.

Violations

Violations of this policy and related procedures may result in disciplinary actions up to and including termination of employment.

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Definitions

Health and Human Services Commission (HHSC)	The administrative agency within the executive department of Texas state government established under Chapter 531, Texas Government Code or its designee, including, but not limited to, the Texas Health and Human Services Agencies.
Provider	An appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and subcontractors, that has a contract with Davis Vision for the delivery of Covered Services to the plan Members.
Appealed Claim	A claim that has been previously adjudicated as a clean claim and the provider is appealing the disposition through written notification and in accordance with the appeal process. Claim payment appeals may also include retrospective medically necessary reviews.

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Exceptions

There are no exceptions allowed.

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Approval Authority

Vice President, Business Compliance/Clinical Administration or authorized delegate

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Related Policies and Documents

Replaces L-QAL-0309-006.05 Provider Complaint and Appeal Process State of Texas

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Revision History

11/01/2012: Removed references to Operational Compliance. Corrected approval authority to encompass authorized delegates. C Turano

11/18/2013: Updated approval authority and procedure template. [CKT]
12/16/2014: Updated procedure owner and approval authority. C Turano
11/16/2015: Updated Owner, Administration sections. Updated Reporting section by Added reporting categories as per TAC 28 Subchapter C (§11.205)(a)(4)), Complaint and Appeal Categories. [CKT]

4/21/2016: Update approval authority, and align appeal timeframes with 2016 Provider Manual. Included TX Medicaid adherence monitoring around resolution timeframes as per TX Medicaid model contract version 2.17. [CKT]
09/22/2017: Updated procedure owner.
08/31/2018: Updated Approval Authority [RTJ]

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