Corporate Procedures

Procedure Name	**Texas - Provider Complaint Process**
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Category	Complaints and Appeals

Approval Date: 08/31/2018

Approved By: Christine Turano

Procedure Overview

Davis Vision provides a process for providers to file a verbal or written complaint that is related to dissatisfaction/concern regarding another provider(s), the health plan, or a member(s). Provider complaint investigation may include peer review when indicated.

Scope

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

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.

Procedures

1. The provider complaint process is communicated via a summary document which is published to a public-facing web site (www.davisvision.com) for both Davis Vision net-work providers and out of net-work providers to access as needed. The summary document is updated in tandem with any changes occurring to this Policy and Procedure.

2. A provider may submit a Provider Complaint by contacting Davis Vision via telephone, in writing or through the Davis Vision Web site, at www.davisvision.com.

3. All complaints are routed to the C&A Department in which an associate documents the following information into an electronic tracking system:

    a) The date and time of receipt of complaint
    b) The name of the associate receiving the complaint
    c) The name of the associate responsible for investigation and resolution
    d) Member's name (when applicable)
    e) Member's identification number (when applicable)
    f) Summary of complaint
    g) Provider's name and provider identification number
    h) Date of acknowledgement
    i) Summary of investigative actions resolution
    j) Date of resolution and notification

4. Davis Vision Associate acknowledges receipt of the Provider Complaint by telephone or in writing, within five (5) calendar days from the date the Provider Complaint is received.

5. Davis Vision completes its review, makes a determination and provides a written Notice of Resolution to the provider within thirty (30) calendar days of receipt. The resolution letter notifies the provider of the opportunity to file a complaint with an external entity when applicable.

    a) Note: According to state law, there are certain complaints that the organization may not be able to inform the provider of the final disposition. In these cases where the company has investigated a provider, and in cases related to quality of care, the organization will notify the provider that the complaint was received and investigated, and inform the provider the final disposition cannot be provided due to peer confidentiality.

6. If a provider is dissatisfied with the Complaint resolution, they have the right to file a Complaint. The following represents appeal avenues for additional review based on complaints which pertain to particular lines of business:

    a) STAR Program: Texas Health and Human Services Commission, HHSC Claims Administrator Contract Management, Mail Code 91X, P.O. Box 204077, Austin, TX 78720-4077

b) CHIP Program and Commercial Programs: The Texas Department of Insurance (TDI), HMO Quality Assurance Section, Mail Code 103-6A, P.O. Box 149104, Austin, TX 78714-9104

7. All complaints are handled in a confidential manner.

8. Davis Vision does not discriminate against a provider for filing a complaint

Reporting

- All provider complaints 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

- Complaint data will be incorporated and presented at Davis Vision's Quality Management Committee meetings on a quarterly basis for tracking and trending purposes.

- *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.

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.

Definitions

Administrative Issues:	Administrative issues may include but are not limited to: inability to maintain a satisfactory provider/member relationship or administrative problems with Davis Vision staff.
Adverse Determination	A determination, rendered upon utilization review, that the health care services furnished or proposed to be furnished to a member are not medically necessary or not appropriate.
Clinical Issues	Clinical issues may include but are not limited to: possible adverse outcome or potential for an adverse outcome in a member's health status due to a provider's care or possible inappropriateness of a Davis Vision provider's behavior.
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.
Provider Complaint	Any unresolved dissatisfaction expressed verbally or in writing by the provider, and on behalf of the provider, concerning any aspect of Davis Vision's Managed Care Operations. The term complaint does not include a misunderstanding or problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the provider.

Exceptions

There are no exceptions allowed.

Approval Authority

Corporate Compliance Officer (CCO) or authorized delegate

Related Policies and Documents

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

Revision History

11/01/2012: Removed references to Operational Compliance and corrected “Approval Authority” section to include “authorized delegates”. C Turano
11/18/2013: Updated approval authority and revised template format. C Turano
08/07/2014: Updated Approval Authority section, amended Reporting section as it relates to Quality Management tracking [CKT].
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]
04/21/2016: Updated approval authority and Included TX Medicaid adherence monitoring around resolution timeframes as per TX Medicaid model contract version 2.17 . [CKT]
09/22/2017: Update procedure owner [CKT]
08/31/2018: Updated Approval Authority [RTJ]