

## Section 10: Complaints & Appeals

---

### *Introduction*

A complaint is a verbal or written expression of dissatisfaction with Driscoll Children's Health Plan concerning a process within the health plan. A complaint is not a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the provider. It is anticipated that the majority of the verbal and written complaints would be resolved with DCHP. A member or provider may initiate the complaint process either by telephone, in person, or in writing, expressing the details of the concerns.

---

### *What is an Appeal?*

There are three (3) types of appeals. They are:

- **Complaint Appeal** is an appeal that occurs when the complainant is not satisfied with the outcome of the complaint.
  - **Adverse Medical Determination Appeal** is an appeal that occurs when there has been a denial of benefit because of lack of medical necessity.
  - **Expedited Appeal** is an appeal at an expedited rate that occurs when the usual timeframe for appeal response may jeopardize the member's health. This expedited appeal may occur for a complaint or an adverse medical determination appeal.
- 

### *CHIP Program: Complaints & Appeals*

#### *Filing a Complaint*

A provider, member, or a provider/someone acting on the behalf of the member may initiate the complaint process either by telephone, in person, or in writing, expressing the details of the concerns. To initiate by telephone, the complainant should call Provider Services at the number shown on this page. If the complainant needs assistance with filing the complaint, they should request this when calling Member Services. Someone within DCHP will assist the complainant.

If a complaint is by telephone or in person, the DCHP representative receiving the initial communication will request that the complainant submit the complaint in writing, when possible.

---

**DCHP Provider Services: 1-877-DCH-DOCS (324-3627)**

**Prior Authorization and Referrals: 1-877-455-1053 (FAX 1-866-741-5650)**

**Case Management:> 1-877-222-2759 (FAX 1-866-741-5650)**

**CHIP Member Services: 1-877-451-5598    STAR Member Services: 1-877-220-6376**

**Member Services FAX: 361-904-0187**

---

A DCHP Complaint Form will be sent to the complainant. The DCHP Complaint Form can be found in **Appendix A** of this Manual. The mailing address and telephone number where complaints may be directed is as follows:

**Driscoll Children's Health Plan**  
**Attn: Compliance Officer**  
**P.O. Box 6609**  
**Corpus Christi, Texas 78466-6609**

A written response will be sent within five (5) business days, acknowledging receipt of the written or verbal complaint. Verbal complainants will be sent a complaint form with the acknowledgement letter. Complaints must be received in writing for action to be taken. All complaints and administrative issues concerning quality of care, utilization management or any medical practice issues will be reviewed by the Quality Improvement Committee. In addition, this may require additional consideration by the appropriate standing subcommittee. The total time for acknowledgment, investigation and resolution may not exceed thirty (30) calendar days from receipt of complaint.

Appeal of Complaint Decision

If the complaint response decision is unacceptable by the complainant, instructions will be given with the response regarding the complaint appeals process, including all time frames and the process will continue on to the appeal procedure. This includes the right to appeal before a Complaint Appeal Panel. In addition to appealing the response to DCHP, the complainant has the right to contact the Texas Department of Insurance by calling **1-800-252-3439**, or write them at **P.O. Box 149104, Austin, Texas 78714-9104**, if he/she is not satisfied with this resolution. DCHP requests that all avenues of resolution regarding the complaint be pursued before contacting the Texas Department of Insurance.

What can the Member do if DCHP denies or limits the member's request for a covered service?

The member, provider, or someone acting on behalf of the member, is denied a request for a covered service by DCHP, they may file an appeal to DCHP. (See the process below for filing an Appeal of Adverse Determination.) Member or provider will be notified of the denial within three days of making the determination via a letter.

Appeal of Adverse Determination

If the Medical Director or physician designee determines that requested services do not meet medical necessity criteria, then medical services may be denied. The provider, member or provider/someone acting on behalf of the member are entitled to request the appeal process through Driscoll Children's Health Plan. The denial letter sent to the Provider and Member will outline the process, along with the appropriate forms, to initiate the appeal. An appeal may be submitted orally or in writing. If the appeal is submitted orally, an appeal form will be sent with the acknowledgement letter for the appellant to complete and return to DCHP.

---

**DCHP Provider Services: 1-877-DCH-DOCS (324-3627)**

**Prior Authorization and Referrals: 1-877-455-1053 (FAX 1-866-741-5650)**

**Case Management:> 1-877-222-2759 (FAX 1-866-741-5650)**

**CHIP Member Services: 1-877-451-5598 STAR Member Services: 1-877-220-6376**

**Member Services FAX: 361-904-0187**

---

An acknowledgement letter will be sent to the appellant within five (5) days of receipt of the appeal. The appeal will be reviewed and a decision rendered within thirty (30) days of receipt of the appeal. The decision letter will include the rationale for the decision, specialist provider that may have assisted in the decision, and information regarding appealing to an Independent Review Organization (IRO). The decision will be made by a provider other than the one that made the original denial. Appellant may request assistance with filing the appeal. They should contact Provider Services to arrange for this assistance.

Expedited Appeal

In cases of emergencies or continued stay in the hospital, an expedited appeal process will be implemented. Appellant may file the request orally or in writing. In addition, the appellant may request assistance in filing the appeal. They should contact Provider Services and request the assistance. Someone within DCHP will provide that assistance. During an expedited appeal, a health care provider who has not previously reviewed the case will review the appeal. The expedited appeal will be completed no later than one (1) working day following the day on which the appeal, including all information necessary to complete the appeal, is made to DCHP. As part of the expedited appeal process, the provider, member, provider/someone acting on behalf of the member, may request the case be directly forwarded to an Independent Review Organization, through the Texas Department of Insurance. The process must be initiated by Driscoll Children's Health Plan, so the proper forms should be completed and submitted to DCHP as soon as possible.

DCHP will make every effort to honor the member's request for an expedited appeal. If the rationale for request does not meet the definition of an expedited appeal (decision warranted quickly due to the member's critical health outcome), DCHP may deny the request. If this happens, the provider may intervene on the Member's behalf and discuss the situation with the Medical Director. The Provider should contact the Medical Director by calling Provider Services at the number shown on this page.

IRO Appeal through TDI

In cases where the member's life and health may be in jeopardy, the provider, member, or provider/someone acting on behalf of the member, may request an appeal directly to an Independent Review Organization (IRO) through the Texas Department of Insurance (TDI). DCHP has the forms necessary to initiate this process. TDI will appoint an IRO to review the case, and a decision will be made expeditiously through the IRO.

If the provider, member, or provider/someone acting on behalf of the member, is not satisfied with the response regarding an appeal for an adverse determination, medical necessity denial, they may request a review by an IRO. This information and the necessary forms are included with the appeal response. The forms must be completed and returned to DCHP to initiate the process. TDI will appoint an IRO to review the case. Decisions of the IRO are final and binding. DCHP will abide by the decision of the IRO, and will incur all expenses of the IRO review.

---

**DCHP Provider Services: 1-877-DCH-DOCS (324-3627)**

**Prior Authorization and Referrals: 1-877-455-1053 (FAX 1-866-741-5650)**

**Case Management:> 1-877-222-2759 (FAX 1-866-741-5650)**

**CHIP Member Services: 1-877-451-5598    STAR Member Services: 1-877-220-6376**

**Member Services FAX: 361-904-0187**

---

---

## ***STAR Program: Complaints & Appeals***

### *Filing a Complaint*

A provider, member, or provider/someone acting on behalf of a member, may file a complaint by calling Provider Services. A member advocate is available to assist with filing the complaint. A complaint may also be filed with the Health and Human Services Commission (HHSC) at **1-800-252-8263**. A complaint may be filed orally, or in writing. A complaint form will be sent to the complainants who file a verbal complaint. To proceed with the investigation of the complaint, the complaint must be received in writing. An acknowledgement letter will be sent within five (5) days of receiving the complaint, with a complaint form, if applicable.

All complaints are reviewed and a response sent within thirty (30) days of receipt of the written complaint. All complaints and administrative issues concerning quality of care, utilization management or any medical practice issues will be reviewed by the Quality Improvement Committee. In addition, this may require additional consideration by the appropriate standing subcommittee.

### *Appeal of Complaint Decision*

If the provider, member, or provider/someone acting on behalf of the member, is not satisfied with the response of the complaint, they may file an appeal. Information regarding the appeal of the complaint decision is included with the decision response. The appeal must be in writing. Appeal decisions are made within thirty (30) days of receiving the appeal. Included in the appeal letter is the process used to make the determination.

### *What can a member do if DCHP denies or limits the Member's request for a covered service?*

The member, provider, or someone acting on behalf of the Member may file an appeal when a denial occurs. (See the Appeal of an Adverse Determination below for how to file this appeal.) Members and providers are notified of denials by a letter. If the denial is a medical necessity denial, the Medical Director issuing the denial will contact the requesting provider and discuss the situation with him/her prior to denying the services. A denial letter is sent out within three (3) days of making the decision.

### *Appeal of Adverse Determination*

The provider, member, or provider/someone acting on behalf of the member has ten (10) days from the date on the denial letter or the date of requested service to appeal the determination. This may be requested verbally or in writing. If the request is received verbally, we will ask that this appeal be put in writing. If the provider is requesting the appeal, the member, or someone acting on behalf of the member, must sign this appeal. If more than ten (10) days is needed to appeal this denial, this must be requested. We may grant up to an additional fourteen (14) days to appeal this denial.

---

**DCHP Provider Services: 1-877-DCH-DOCS (324-3627)**

**Prior Authorization and Referrals: 1-877-455-1053 (FAX 1-866-741-5650)**

**Case Management:> 1-877-222-2759 (FAX 1-866-741-5650)**

**CHIP Member Services: 1-877-451-5598    STAR Member Services: 1-877-220-6376**

**Member Services FAX: 361-904-0187**

---

We will send an acknowledgement letter within five (5) days of receiving the appeal. We will complete the appeal review within thirty (30) days from receipt of the appeal. If we need additional time for the review, we will notify the appellant with the rationale for needing more time. (Appeals for denials of service for not being a covered benefit is a complaint, not an appeal for adverse determination.)

Members may be required to pay the cost of services furnished while the appeal is pending, if services were delivered before approval was given.

Members needing assistance with filing the appeal should call the STAR or CHIP Member Services toll free number and request this assistance. A Member Advocate will be available to assist the member.

*Expedited Appeal*

An expedited appeal can be requested when a decision needs to be made quickly based on the health status of the member, and taking time for the standard appeal process could jeopardize the like and health of the member. Requests can be made verbally or in writing. A member advocate can assist the member with this process. For more information, or to request an expedited appeal, contact Provider Services. Once the expedited appeal is received, a decision will be made within one day from receipt.

DCHP will make every effort to honor the member's request for an expedited appeal. If the rationale for request does not meet the definition of an expedited appeal (decision warranted quickly due to the member's critical health outcome), DCHP may deny the request. If this happens, the provider may intervene on the Member's behalf and discuss the situation with the Medical Director. The Provider should contact the Medical Director by calling Provider Services at the number shown on this page.

*State Fair Hearing through HHSC*

The member has a right to request a State Fair Hearing at any time during the DCHP appeal process. If the member does not agree with the DCHP appeal decision, they may request for a Fair Hearing from the State. They have ninety (90) days from the date on the letter to request a Fair Hearing. If a request is not received within ninety (90) days, the right for a hearing is forfeited. To request a Fair Hearing, the member must contact the Health and Human Services Commission (HHSC) at **1-800-252-8263** or by mailing to

**Texas Health and Human Services Commission  
Appeals Division, Fair Hearings Y-613  
P.O. Box 149030  
Austin, Texas 78714**

---

**DCHP Provider Services: 1-877-DCH-DOCS (324-3627)**  
**Prior Authorization and Referrals: 1-877-455-1053 (FAX 1-866-741-5650)**  
**Case Management:> 1-877-222-2759 (FAX 1-866-741-5650)**  
**CHIP Member Services: 1-877-451-5598    STAR Member Services: 1-877-220-6376**  
**Member Services FAX: 361-904-0187**

---

The Member does not have a right to a Fair Hearing if Medicaid/STAR does not cover the service requested.

Once a Fair Hearing is requested, a letter will be sent by the State hearing officer. The letter will provide the date and time of the hearing, and what information will be needed at the hearing. This hearing may be held by telephone, or the information can just be submitted and reviewed by the hearing officer and a decision reached. HHSC will give a final decision within ninety (90) days from the date the hearing was requested.

---

---

**DCHP Provider Services: 1-877-DCH-DOCS (324-3627)**

**Prior Authorization and Referrals: 1-877-455-1053 (FAX 1-866-741-5650)**

**Case Management:> 1-877-222-2759 (FAX 1-866-741-5650)**

**CHIP Member Services: 1-877-451-5598    STAR Member Services: 1-877-220-6376**

**Member Services FAX: 361-904-0187**

---

---