



SCOTT & WHITE HEALTH PLAN

POLICY NUMBER: MS 1.1
EFFECTIVE DATE: 9-97; 12-19-05;
4-7-08

CUSTOMER SERVICES POLICIES AND PROCEDURES

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TOPIC: Scott & White Health Plan Inquiry Policy and Procedure (Commercial Group & Health Plus)

I. POLICY

Scott & White Health Plan (SWHP) shall provide internal procedures for an enrollee, practitioner, provider or other person designated to act on behalf of an enrollee to question a decision or voice an inquiry and to receive a satisfactory response in a timely manner.

II. PURPOSE

To standardize procedures for handling inquiries in a consistent manner and in accordance with SWHP standards that complies with the National Committee for Quality Assurance (NCQA), the Texas Department of Insurance (TDI), and other regulatory agencies.

III. DEFINITIONS

An inquiry is a request for information or clarification about a SWHP practitioner, provider, benefit, or decision.

IV. PROCEDURE

1. SWHP receives a question from an enrollee about a SWHP practitioner, provider, a benefit, or decision. A Customer Service Coordinator (CSC) is responsible for answering inquiries in a timely manner.
2. Within three (3) business days of receipt, the CSC responds to the inquiry. If the enrollee receives a satisfactory explanation about the inquiry, then the CSC documents the transaction in the computer phone log and closes the inquiry. If the enrollee does not receive a satisfactory answer to the inquiry, the CSC asks the member if he or she would like to file a Complaint with the SWHP. If the member chooses to pursue the Compliant procedure, the CSC begins the SWHP Complaint procedure.

APPROVAL: _____
(Medical Director)

(Associate Medical Director)

(Operations Director)

(Health Services Director)

PROPOSED: (9-97);12-19-05; 4-7-08

APPROVED: 9-97; 12-19-05; 4-7-08

REVIEWED: 11-03; 12-19-05; 4-7-08

REVISED: 11-03; 12-19-05



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POLICY NUMBER: MS1.2
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TOPIC: Scott & White Health Plan Complaint Policy and Procedure (Commercial Group and Health Plus)

I. POLICY

Scott & White Health Plan (SWHP) shall provide internal procedures for an enrollee, practitioner, provider or other person designated to act on behalf of an enrollee to voice a Complaint and to receive a satisfactory response to the Complaint in a timely manner. This procedure shall reflect the SWHP Complaint Procedure as outlined in the Attachment to the SWHP Evidence of Coverage.

II. PURPOSE

To standardize procedures for handling Complaints (including Emergent cases) in a consistent manner and in accordance with SWHP standards which comply with the National Committee for Quality Assurance (NCQA), the Texas Department of Insurance (TDI), and other regulatory agencies.

III. DEFINITIONS

An inquiry is a request for information or clarification about a SWHP practitioner, provider, benefit, or decision.

- A. A Complaint is any oral or written expression of dissatisfaction with any aspect of the Health Plan's operations, including but not limited to dissatisfaction with plan administration; procedures related to review or appeal of adverse determination; the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions expressed by a complainant. The term does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information.
- B. Complainant is an enrollee, or a practitioner, provider, or other person designated to act on behalf of an enrollee who files a complaint.

IV. PROCEDURE

- A. Oral Complaint
 1. SWHP receives an oral expression of dissatisfaction from Complainant. This signals the Customer Service Coordinator (CSC) to begin the Oral Complaint procedure. A CSC is responsible for assuring the resolution of the Oral Complaint.



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2. The CSC processes the Concern by documenting the Oral Complaint in the Macess documentation log and forwarding by customer service form (CSF) to the Health Services Division (HSD) Department Secretary responsible for intake of dispute resolution requests. The HSD Department Secretary completes an Oral Complaint checklist. The checklist ensures a timely resolution and compliance with SWHP standards.
3. The CSC immediately determines if the Oral Complaint involves an Emergent Case. An Emergent Case is a medical condition of a serious nature that requires concurrent review or an appeal of a denial of continued stay for hospitalization. The Medical Director may be asked to help make an Emergent Case determination.
4. If the case is determined to be an Emergent Case the CSC immediately faxes the Oral Complaint to SWHP Health Services Division to proceed through Utilization Review and/or Technical Assessment Review process. SWHP resolves the Oral Complaint in an expedited manner that does not exceed one (1) business day from the Complainant's request. The CSC is responsible for communication between the Health Services Division and the complainant. The CSC notifies the Complainant of further appeal rights within one (1) business day time frame.
5. If the case is determined to be a Non-Emergent case, no later than five (5) business days after the date of receipt of Oral Complaint, the HSD Department Secretary sends the complainant an acknowledgment letter and a one page complaint form. The complaint form has a unique identification number with the CSC's initials, the date and sequential number. The acknowledgment letter includes the date SWHP received the Oral Complaint, the unique identification number, and the Attachment of the SWHP Complaint Procedure.
6. No later than three (3) business days after the receipt of the Oral Complaint, the HSD Department Secretary documents and appropriately categorizes the Oral Complaint in the Patient/Member Complaint database.
7. No later than three (3) business days after the receipt of the Oral Complaint, the HSD Department Secretary sends a copy of the Oral Complaint to the appropriate department for a full investigation of the substance of the Complaint, including any aspects of clinical care involved. The transmission can be via FAX, internal mail or U.S. mail. The HSD Department Secretary requests a response from the investigating department within twenty (20) calendar days. The investigating departments are as follows:

SWHP Medical Director

- * Handicapped Determination
- * Denials
- * Out-of-Plan Benefit Denials
- * Quality of Care
- * Quality of Service

SWHP Finance

- * Coordination of Benefits
- * Subrogation (HRI)

SWHP Administration

- * SWHP Staff Complaints
- * Eligibility
- * Marketing Materials
- * Premium Rates

Scott & White Institutional Pharmacy

- * Pharmacy Formulary Issues
- * Quality of Service of Pharmacy Staff



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- * SWHP Billing
- * Claims Process Delays
- * Workers Compensation
- * Other Issues with Pharmacy

SWHP Provider Relations

- * Issues with Contracted Providers that does not involve other departments
8. Within fifteen (15) calendar days of the investigating department's receipt of Oral Complaint, the investigating department sends written response to the complainant or input to the HSD Department Secretary. If the HSD Department Secretary does not receive a copy of the response or input from the investigating department within fifteen (15) calendar days, the HSD Department Secretary notifies investigating department on the fifteenth calendar day and every five (5) calendar days thereafter until receipt of the response.
 9. No later than thirty (30) calendar days after the receipt of the Oral Complaint, the investigating department or the CSC will send the complainant a response letter explaining the specific medical and/or contractual reasons for the resolution and the specialization of any physician or other provider consulted and any actions taken if appropriate. The response letter will contain a full description of the process for appeal, including the time frames for the appeals process and the time frames for the final decision on the appeal.
 10. The HSD Department Secretary closes the Complaint database log entry by noting the resolution and the date the case was closed. The CSC documents on the Oral Complaint checklist any reasons for delay in response if the Oral Complaint is not resolved within thirty (30) calendar days.
 11. The HSD Department Secretary files all original documentation in the Oral Complaint Log. All documents are filed in chronological order with the concern checklist filed on top. All records are kept for a minimum of three (3) years.
 12. All categorized Oral Concerns are reported monthly to the Medical Directors and the Quality Improvement Sub-Committee.

If the complaint form is received from the complainant at any step during the Oral Complaint Procedure, the HSD Department Secretary documents the date received on the Oral Complaint checklist and immediately begins the Written Complaint Procedure.

B. Written Complaints

A. Initial Written Complaints

1. SWHP receives a written expression of dissatisfaction or a completed complaint form from the complainant. This signals the CSC to begin the Written Complaint Procedure. A CSC is responsible for assuring the resolution of the Complaint.



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2. The HSD Department Secretary documents the receipt date on the complaint form or Written Complaint and begins documenting the steps on a Written Complaint checklist and documenting in the Maces documentation log and in the Patient/Member Complaint database. The checklist ensures a timely resolution and compliance with SWHP standards.
3. The HSD Department Secretary immediately determines if the Complaint involves an Emergent Case. An Emergent Case is a medical condition of a serious nature that requires concurrent review or an appeal of a denial of continued stay for hospitalization. The Medical Director may be asked to help make an Emergent Case determination.
4. If the case is an Emergent Case the HSD Department Secretary immediately forwards the Complaint to SWHP Health Services Division to proceed through the Utilization Review and/or Technical Assessment Committee review process. SWHP resolves the Complaint in an expedited manner that does not exceed one (1) business day from the complainant's request. The CSC is responsible for communication between the Health Services Division and the complainant. The CSC notifies the complainant of further appeal rights within one (1) business day time frame.
5. If the case is determined to be Non-Emergent, no later than five (5) business days after the receipt of the Written Complaint the HSD Department Secretary immediately does the following:
 - * sends a copy of the Written Complaint to the appropriate investigating department via FAX, internal mail or U.S. mail;
 - * requests response/input from the investigating department within fifteen (15) calendar days;
 - * sends the complainant an acknowledgment letter that includes the date SWHP received the Written Complaint, the unique identification number and the SWHP Complaint Procedure; and
 - * documents the Complaint in the Patient/Member Complaint database
6. Within fifteen (15) business days of the investigating department's receipt of the Written Complaint, the investigating department sends a written response to the complainant or input to the HSD Department Secretary. If the HSD Department Secretary does not receive a copy of the response or input from the investigating department within fifteen (15) calendar days, the HSD Department Secretary notifies the investigating department on the fifteenth business day and every five (5) calendar days thereafter until receipt of the response.
7. Within thirty (30) calendar days of the receipt of an initial Written Complaint, the investigating department sends the complainant a written response or the CSC will send the complainant a response letter explaining the specific medical and/or contractual reasons for the resolution and the specialization of any physician or provider consulted. The response letter will contain a full description of the process for Appeal, including the time frames for the Appeal process and the time frames for the final decision on the Appeal.



B. Complaint Form Received Before Oral Complaint Is Resolved

1. If a complaint form is received from the complainant before the initial Oral Complaint has been resolved, no later than three (3) business days after receipt of the complaint form, the HSD Department Secretary does the following:
 - * faxes a copy of the complaint form to the investigating department notifying them of the change from Oral Complaint status to Written Complaint status;
 - * reminds the investigating department of the requested response within fifteen (15) calendar days of receipt of initial Oral Complaint (not receipt of the complaint form);
 - * changes classification from Oral Complaint to Written Complaint in the Complaint database; and
 - * documents the change in classification on Oral Complaint checklist
2. Within fifteen (15) calendar days of the investigating department's receipt of the Oral Complaint, the investigating department sends a written response to the complainant or input to the HSD Department Secretary. If the HSD Department Secretary does not receive a copy of the response or input from the investigating department within fifteen (15) calendar days, the HSD Department Secretary notifies the investigating department on the fifteenth calendar day and every five (5) calendar days until receipt of response.
3. Within thirty (30) calendar days of receipt of the initial Oral Complaint, the investigating department sends the complainant a written response or the CSC will send the complainant a response letter 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 Appeal, including the time frames for the Appeal process and the time frames for the final decision on the Appeal.
4. The HSD Department Secretary closes the Complaint database entry by noting the resolution and the date the case was closed. The HSD Department Secretary documents on the Written Complaint checklist any reasons for delay in response if the Written Complaint is not resolved within thirty (30) calendar days.
5. The HSD Department Secretary files all original documentation in the Written Complaint log. All documents are filed in chronological order with the Written Complaint checklist filed on top. All records are kept for a minimum of three (3) years.
6. All categorized Written Complaints are reported monthly to Medical Directors and the Quality Improvement Sub-Committee.
7. An annual Complaint summary is reported to the Texas Department of Insurance Commissioner by March 1st of each year, in accordance with the requirements contained in 28 TAC §19.1716(b).



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APPROVAL: _____
(Medical Director)

(Associate Medical Director)

(Operations Director)

(Health Services Director)

PROPOSED: (9-97); 12-19-05;
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TOPIC: Scott & White Health Plan Appeal Procedure (Non U.M. Issues)
(Commercial Group and Health Plus)

I. POLICY

Scott & White Health Plan (SWHP) shall provide internal procedures for an enrollee, practitioner, provider or other person designated to act on behalf of an enrollee to appeal SWHP decisions.

II. PURPOSE

To standardize procedures for handling appeals in accordance with SWHP standards which comply with the National Committee for Quality Assurance (NCQA), the Texas Department of Insurance (TDI), and other regulatory agencies.

III. DEFINITIONS

- A. An Appeal is an oral or written request for the SWHP to reverse a previous decision.
- B. A Complainant is an enrollee, practitioner, provider or other person designated to act on behalf of an enrollee who files a complaint.

IV. PROCEDURE

- A. SWHP receives a request to reverse a previous decision, or Complaint, from Complainant. This signals Customer Services to begin Appeal Procedure. The request may be submitted by an enrollee, a person acting on behalf of an enrollee or the enrollee's physician or health care provider and may be made orally or in writing. A Customer Service Coordinator (CSC) is responsible for assuring resolution of the Appeal.
- B. Within five (5) business days of receipt of the Appeal, the CSC processes the Appeal by documenting the substance of the Appeal in the Macess documentation log and forwarding by customer service form (CSF) to the Health Services Division (HSD) Department Secretary responsible for in-processing of dispute resolution requests. The HSD Department Secretary appropriately categorizes the Appeal in the Patient/Member Complaint database and initiates the appeal checklist. The appeal checklist ensures a timely resolution and compliance with SWHP procedures.
- C. Within five (5) business days of receipt of Appeal, HSD Department Secretary sends an acknowledgment letter to Complainant. The acknowledgment letter includes the date SWHP received the Complainant's request for Appeal; the right of the Complainant to appear in person or communicate by other appropriate means; the



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right to have a representative to appear if the Complainant is a minor or disabled; the right of the Complainant to present written or oral information; the right of the

Complainant to present alternative expert testimony; and the right of the Complainant to request the presence of and question any person responsible for making the prior determination which resulted in the Appeal. If the Appeal is received orally the Health Plan will also enclose a one page Appeal form, which must be returned for prompt resolution of the Appeal.

- D. Within three (3) business days of receipt of the Appeal, the HSD Department Secretary moves all documentation except the complaint checklist from the complaint log to the appeals log.
- E. The CSC arranges with the Complainant the date, time, and place of a hearing before an Appeal Panel. The hearing is held within thirty (30) calendar days of receipt of Appeal and where the Complainant would normally receive health care services within the SWHP Service Area. The Appeal Panel is composed of equal members of SWHP staff, physicians, or other providers and enrollees. The physicians or other providers on the Appeal Panel have experience in the area of care that is in dispute and are independent of any physician or provider who made the determination. No member of the Appeal Panel has previously been involved with this case. If specialty care is in dispute, the Appeal Panel must include an additional person who is a specialist in the field of care to which the Appeal relates. The enrollees on the Appeal Panel are not employees of SWHP.
- F. Investigation of the substance of the appeal, including all aspects of clinical care involved is carried out during the complaint process.
- G. No later than five (5) business days prior to the scheduled hearing, unless the Complainant agrees otherwise, the HSD Department Secretary sends the Complainant or Complainant's designated representative the following documentation:
- any documentation to be presented to the panel by SWHP's staff
 - the specialization of any physicians or providers consulted during investigation
 - the name and affiliation of each SWHP representative on the panel
- H. Within three (3) calendar days after the hearing but no later than thirty (30) calendar days after the receipt of the appeal request, the CSC notifies the Complainant of SWHP's decision. The written notification includes a list of the individuals who participated in the hearing, with titles and credentials; a statement of the reviewer's understanding of the pertinent facts of the Appeal: reference to the specific medical determination, clinical basis, and contractual criteria used as the basis for the decision; the toll-free telephone number and the address of the Texas Department of Insurance; and in cases involving a denial of services, instructions for requesting a written copy of any review criteria used.



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- I. The HSD Department Secretary documents in the Complaint database the actions taken and the date the case was closed.
- J. The HSD Department Secretary files all original documentation in the appeals log in chronological order with the appeal checklist on top. All records are kept for a minimum of three (3) years.
- K. All categorized appeals are reported monthly to Medical Directors and the Quality Improvement Sub-Committee.
- L. An annual Appeal summary is reported to the Commissioner of Texas Department of Insurance by March 1st of each year, in accordance with the requirements contained in 28 TAC §19.1716(b).
- M. The responses from physicians regarding complaints involving quality of medical care received by the Medical Director are protected under Peer Review statute and will be designated as confidential by stamp by the Medical Director.
- N. Provider Appeal Panels are composed of three (3) providers, who have experience in the same field of care to which the Appeal relates.

APPROVAL: _____
(Medical Director)

(Associate Medical Director)

(Operations Director)

(Health Services Director)

PROPOSED: 9-97; 12-19-05; 4-7-08

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TOPIC: Scott & White Health Plan Appeal Procedure (U.M. Issues Only)
(Commercial Group and Health Plus)

I. POLICY

Scott & White Health Plan (SWHP) shall provide procedures for an enrollee, practitioner, provider or other person designated to act on behalf of an enrollee to appeal SWHP decisions internally or externally through the Independent Review Organization (IRO) process.

II. PURPOSE

To standardize procedures for handling appeals in accordance with SWHP standards which comply with the National Committee for Quality Assurance (NCQA), the Texas Department of Insurance (TDI), and other regulatory agencies.

III. DEFINITIONS

- A. An Appeal is an oral or written request for the SWHP to reverse a previous decision.
- B. An Appeal to an Independent Review Organization (IRO) is a request for SWHP to reverse a decision that resulted in an Adverse Determination
- C. An Adverse Determination is defined as a determination made by SWHP that the health care services furnished or proposed to be furnished to the member are not medically necessary or medically appropriate as defined in the Evidence of Coverage.
- D. A Complainant is an enrollee, practitioner, provider or other person designated to act on behalf of an enrollee who files a complaint.
- E. A life-threatening condition is defined as a disease or other medical condition with respect to which death is probable unless the course of the disease or condition is interrupted.

IV. PROCEDURE

A. Appeals

- 1. SWHP receives a request to reverse a previous decision, or Complaint regarding medical necessity, from Complainant. This signals the Customer Service Coordinator (CSC) to begin the Appeal Procedure. The request may be submitted by an enrollee, a person acting on behalf of an enrollee or the enrollee's practitioner or health care provider and may be made orally or in writing. If a provider appeals an adverse determination, then another specialist in that panel will review the appeal. Investigation and resolution of complaints or appeals relating to presently occurring emergencies, or denials of continued stays for hospitalization shall be concluded in accordance with the medical or dental immediacy of the case but will not exceed one (1) business day from the date the complaint or, as appropriate, request for appeal is received by the Health Plan. A CSC is responsible for assuring resolution of the Appeal.



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2. The CSC immediately contacts the SWHP Medical Director to determine if the Appeal involves a life-threatening condition or meets the definition of medical necessity.
3. If the case is determined to be life threatening, the CSC asks the Complainant if he/she would like to follow the internal Appeal process at SWHP or the external review process within an independent review organization. If the Complainant chooses to pursue the external review process, proceed to Section IV, B, Request for External Review, #2.
4. If the Complainant chooses to pursue the internal Appeal process the CSC immediately processes the Appeal by documenting the Appeal in the Macess documentation log and forwarding by customer service form (CSF) to the Health Services Division (HSD) Department Secretary responsible for intake of the dispute resolution request. The HSD Department Secretary handling the intake then forwards the Appeal to the HSD clinical staff to proceed through internal review, which may include the Technical Assessment Committee review process. SWHP resolves the Appeal in an expedited manner that does not exceed one (1) business day from the date of the Complainant's request. In lieu of an Appeal Panel, a physician who has not previously reviewed the case and is of a similar specialty as typically manages the medical condition resolves the appeal. The CSC is responsible for assisting in communication between the HSD and the Complainant. The CSC notifies the Complainant of further appeal rights to an IRO within one (1) business day time frame.
5. If the appeal case is determined to be Non-Emergent, within five (5) business days of receipt of the appeal, the HSD Department Secretary documents the substance of the appeal and appropriately categorizes the appeal in the Patient/Member Complaint database and initiates the appeal checklist. The appeal checklist ensures a timely resolution and compliance with SWHP procedures.
6. Within five (5) business days of receipt of Appeal, the HSD Department Secretary sends an acknowledgment letter to Complainant. The acknowledgment letter includes the date SWHP received the Complainant's request for Appeal; the right of the Complainant to provide additional written or oral information; and the right of an immediate appeal to an IRO or an appeal to an IRO after appeal rights at the Health Plan have been exhausted. If the Appeal is received orally the Health Plan will also enclose a one page Appeal form, which must be returned for prompt resolution of the Appeal.
7. Within three (3) calendar days after the decision but no later than thirty (30) calendar days from the date of the receipt of the appeal request, the CSC notifies the Complainant of SWHP's decision and gives the Complainant further appeal rights. The written notification includes a list of the individuals who participated in the decision, with titles and credentials; a statement of the reviewer's understanding of the pertinent facts of the Appeal; reference to the specific medical determination, clinical basis, and contractual criteria used as the basis for the decision; the toll-free telephone number and the address of the Texas Department of Insurance; and in cases involving a denial of services, instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used.



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8. The HSD Department Secretary documents in the Complaint database the actions taken and the date the case was closed.
9. The HSD Department Secretary files all original documentation in the appeals log in chronological order with the appeal checklist on top. All records are kept for a minimum of three (3) years.
10. All categorized appeals are reported monthly to Medical Directors and the Quality Improvement Sub-Committee.
11. An annual Appeal summary is reported to the Commissioner of Texas Department of Insurance by March 1st of each year, in accordance with the requirement contained in 28 TAC §19.1716(b).

B. Request for External Review

1. The external review process will be initiated by the CSC when Scott & White Health Plan receives one of the following:
 - a) A request involving a life-threatening condition.
 - b) A request to reverse a previous Adverse Determination.
2. Upon immediate receipt of the Appeal request, the Customer Service Manager documents the Appeal in the computer phone log and notifies Health Services Division (HSD) Utilization Manager. The HSD Utilization Manager will immediately contact the Medical Director to confirm the Adverse Determination was one involving denial of medical necessity or appropriate services. The Appeal request and "Request for Assignment of Independent Review Organization" form is faxed to Texas Department of Insurance for assignment to an IRO.
3. Within three (3) days of the receipt of "Notification of IRO" form for case assignment from the Texas Department of Insurance, the SWHP Customer Service Manager sends by FAX, overnight delivery or delivery by Health Plan staff, copies of the following information to the IRO:
 - any medical records of the enrollee that are relevant to the review;
 - any documents used by the plan in making the determination;
 - the written notification described in this document;
 - any documentation and written information submitted to the Health Plan in support of the Appeal
 - a list of each physician or health care provider who has provided care to the enrollee and who may have medical records relevant to the Appeal
4. Upon receipt of the form "Notice of Independent Review Decision" from the IRO, the Customer Service Manager files all original documentation in the appeals log in chronological order. All records are kept for a minimum of three (3) years.



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- 5. All categorized appeals are reported monthly to Medical Directors and the Quality Improvement Sub-Committee.

- 6. An annual Appeal summary is reported to the Commissioner of Texas Department of Insurance by March 1st of each year, in accordance with the requirement contained in 28 TAC §19.1716(b).

APPROVAL: _____
(Medical Director)

(Associate Medical Director)

(Operations Director)

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