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 Scope: Medical Directors
 Cross Reference: TDI Regs, NCQA Stds.
SWHP P/P CR 10, II, B
 : Originated by QI Department
 Approved by (Credentials Committee Chair)
(President, SWHP)

POLICY and PROCEDURE

Practitioner or Provider Appeal Processes

TOPIC: Practitioner or Provider Appeal Rights and Report to Authorities

CATEGORY: Credentialing

I. POLICY:

In order to provide a high quality medical care network for members, Scott and White Health Plan provides a fair hearing and appeal process, processes for altering the practitioner’s or provider’s participation with the Plan and a process for reporting to appropriate authorities.

If there is no immediate or serious danger to members’ health or safety, or an action by a state medical board, or medical licensing board, or other licensing board, or other government agency, that effectively impairs the practitioner’s or provider’s ability to practice medicine, or another profession, or a case of fraud or malfeasance, the practitioner or provider has the right to appeal the findings of the review/assessment or the conclusion. The result of the review/assessment may result in a letter of concern, probationary period, remedial formal medical education or termination.

II. PROCEDURE:

1. To request an appeal, the practitioner or provider must submit a request in writing. On request and before the effective date of action (but within a period not to exceed 60 days) a practitioner or provider shall be entitled to a review by an appeal panel.
2. When the practitioner or provider requests an appeal, the Medical Director may either review his/her report in light of the practitioner’s or provider’s request and make appropriate alterations, or approve the request for the appeal.
3. The appeal panel will be appointed from physician and practitioner or provider members of the standing Quality Improvement SubCommittee and include at least one representative in the practitioner’s or provider’s same or similar specialty, if available.
4. Written notice will be given to the practitioner or provider and Medical Director not more than five calendar days after the date is set. A follow-up telephone call will be made to the practitioner or provider confirming receipt of the notice. This written notice will include the practitioner’s or provider’s rights at the hearing.



- a. The right to notice of date, time and location of hearing
 - b. The identity of those persons requested to appear to support the report and conclusions
 - c. Practitioner or provider has the right to challenge any appeal panel member due to demonstrated lack of impartiality or status as competitor. This challenge will be in writing and delivered to the Medical Director not less than 96 hours prior to the established hearing. The Medical Director will decide on the merits of the challenge within 24 hours of its receipt. If the challenge is determined to be valid, the challenged panel member will be replaced in time to conduct the hearing, or the Medical Director will continue the hearing date to not more than five days thereafter.
 - d. The right to examine and cross-examine those called to testify
 - e. The right to be represented by an attorney
 - f. The right to present relevant evidence
 - g. The right to make a transcript of the hearing at his/her cost, or obtain a copy of transcript made at the request of the Health Plan, at a proportional cost
 - h. The right to present a written statement at the conclusion of the hearing
 - i. The right to a written copy of the decision of the hearing official or panel, including basis of the decision, within ten calendar days of its issuance
5. The decision of the appeal panel must be considered by SWHP, but is not binding on SWHP.
 6. Upon request, SWHP shall provide the affected practitioner or provider a copy of the recommendation of the appeal panel and SWHP's determination. The practitioner or provider shall be entitled, on request, to an expedited review process by SWHP.
 7. The Medical Director may immediately terminate the right of any practitioner or provider to serve Health Plan members if the practice or performances of acts pose an immediate or serious danger to members' health or safety, or an action is taken by a state medical board, or medical licensing board, or other licensing board, or other government agency, that effectively impairs the practitioner's or provider's ability to practice medicine, or another profession, or in case of fraud or malfeasance. Before terminating a practitioner's or provider's participation in the SWHP, a written explanation shall be furnished to the practitioner or provider of the reason(s) for termination.
 8. The appeal process is not available to practitioners or providers who lose their right to serve Health Plan members because of an employment relationship or contract affiliation, either group or individual with a legal entity providing the services of professionals to Health Plan. When the practitioner's or provider's employment relationship is terminated, the right to serve Health Plan members is also terminated. The practitioner or provider will be treated as an out-of-network practitioner or provider.



**SCOTT
& WHITE**
HEALTH PLAN

POLICY / PROCEDURE

**TOPIC: Practitioner or Provider Appeal
Process**

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9. SWHP will provide notification of the termination of a practitioner or provider to Health Plan members receiving care from that practitioner or provider, at least 30 days before the effective date of the termination. Notification of termination of a practitioner or provider to Health Plan members for reasons related to imminent harm may be given immediately.
10. The Health Plan Medical Director for Systems Improvement as Chair of the SWHP Credentials Committee shall report any adverse action to applicable state and federal agencies, including the National Practitioner Data Bank as required by law.



Practitioner/Provider Appeal Request Form

In order to expedite the process of your appeal, this form should be used to submit Practitioner/ Provider appeal requests to Scott & White Health Plan. Please utilize Practitioner/ Provider claim adjustment form for adjustments. In order to be eligible to file a Practitioner/ Provider appeal, you must be a SWHP contracted Practitioner/ Provider, have a SWHP approved referral on a SWHP member, or have a Confirmed Authorized Representative (CAR) for a SWHP SeniorCare member.

Please complete all fields on the form, attach any pertinent supporting documentation and send the appeal to:

Scott & White Health Plan
Attn: Practitioner/ Provider Appeal Coordinator
2401 S. 31st Street
Temple, TX 76508
Telephone: 254-298-3088
Fax Number: 254-298-3090

Practitioner/ Provider Name: _____ Contact Name: _____

Address: _____

NPI #: _____ Contact Phone Number: _____

Member ID _____ Member Name _____

Date of Service _____ Appeal Submission Date _____

Appeal Type
<input type="checkbox"/> Pre-Certification/ Prior Authorization Denials
<input type="checkbox"/> Filing Limit
<input type="checkbox"/> Contract rate or payment policy
<input type="checkbox"/> Request for additional information Please Specify:

Supporting documentation for a Practitioner/ Provider appeal may include the following: Original RAS, surgical notes, office visit notes, pathology reports, medical invoices, medical record entries, letters of recommendation describing the issue. **All appeals must be submitted within 45 days of the date of the adverse determination by SWHP to receive consideration.**

Quick Reference Guide Practitioner/ Provider Appeal Form

This guide will help you in correctly submitting the Scott & White Health Plan Practitioner/ Provider Appeal Form. It is not meant to contradict or replace SWHP's procedure or payment policies. For the most up-to-date information regarding the appeal process, please refer to the Provider Manual ("Appeals Section") at our website: www.swhp.org. Please note that failure to abide by the following may affect your compliance with SWHP's Practitioner/ Provider appeals filing limit policy.

- Complete all information required on the Practitioner/ Provider Appeal Form; incomplete appeal submissions will be returned.
- Attach the claim form and all supportive documentation to the completed Appeal Form.
- Within your original EOP, if you have multiple denials, choose the primary denial for the appeal type.
- Applicable filing limit standards apply.

Appeal Type	Examples (not intended to be all inclusive)
Pre-Certification/ Prior Authorization Denials	<ul style="list-style-type: none"> • A claim was denied because no notification or authorization is on file. • A claim denied for exceeding authorized limits.
Filing Limit	<ul style="list-style-type: none"> • A first time claim submission that denied for, or is expected to deny for untimely filing. • A reappeal of a claim denied for insufficient filing limit documentation. • Claim originally submitted with misidentified member or billed to wrong carrier, resulting in untimely filing to SWHP.
Contract rate or payment policy	<ul style="list-style-type: none"> • Practitioner/ Provider believes that incorrect contract terms/ rates were applied to payment made resulting in either an under or over payment. • Practitioner/ Provider believes that final claim payment was incorrect because of global reimbursement or (un) bundling of billed services (e.g. claim editing software)
Request for additional information Please Specify:	<ul style="list-style-type: none"> • A first time claim submission that denied for additional information. • A procedure code that was denied or not submitted with: operative notes, anesthesia notes, pathology report, and/or office notes.