Notice of Complaint and Appeal Procedures - TEXAS

Please read this notice carefully. Please also review your plan documents and Explanation of Benefits you receive with a benefit decision resulting from a claim or elective request for a pre-treatment estimate of benefits. This notice contains important information about how to file complaints or appeals.

I. Definitions

"Adverse Determination" means that benefits are not available based on a utilization review determination that services provided or proposed are not medically necessary or are experimental. All adverse determinations are made by licensed dentists. Adverse determinations are made in accordance with the Utilization Review Agent's (URA) Clinical Guidelines, which are based upon Current Dental Terminology nomenclature and definitions as well as professional clinical standards of care garnered through clinical experience and publications by organized dentistry.

"Complaint" means an oral or written expression of dissatisfaction concerning the URA's process in conducting a utilization review. The term "complaint" does not include an expression of dissatisfaction constituting an appeal or a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or by clearing up the misunderstanding to the satisfaction of the complaining party

"Independent Review Organization" ("IRO") means an entity authorized by the Texas Department of Insurance to provide an external review of an adverse determination.

"Prospective Review" means a benefits review prior to receiving a service. Prospective reviews are not required under this policy, but you or your provider may choose to request a pre-treatment estimate of benefits before a service is performed.

"Reasonable Opportunity" means at least one documented good faith attempt to contact the provider of record that provides an opportunity for the provider of record to discuss the services under review with us during normal business hours prior to issuing a prospective, concurrent, or retrospective utilization review adverse determination:

(A) no less than one working day prior to issuing a prospective utilization review adverse determination;
(B) no less than five working days prior to issuing a retrospective utilization review adverse determination; or
(C) prior to issuing a concurrent or post-stabilization review adverse determination.

"Retrospective Utilization Review" means a form of utilization review for health care services that have been provided to a member. Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted.

II. Our Benefit Notices

If we make an adverse determination as defined above, after giving the treating provider a reasonable opportunity for discussion, you, an individual acting on your behalf, and the provider will have access to our appeals process, even if the discussion does not occur. An Explanation of Benefits or Payment will also be included, that includes:

1. principal reason for the benefit decision, and
2. the clinical basis and description or source of screening criteria

For adverse determinations, you, an individual acting on your behalf, or the provider have a right to request a review by an IRO. You can request an immediate review by an IRO in cases of life threatening conditions. Please find attached the Independent Review request forms.

III. Designated Person Responsible For Complaints and Appeals Management

Name:	Bruce Mieth Senior Vice President – Group Operations
Address:	P.O. Box 82657 Lincoln, NE 68501-2657
Web:	https://www.ameritas.com
Phone:	877-897-4328 (Toll-Free)
Fax:	402-309-2579

IV. Levels of Review Available

A. Our Internal Review

The member or someone acting on the member's behalf and the provider of record have the right to appeal an adverse determination (denial) orally or in writing. A licensed dentist who has not previously reviewed the case will make the appeal decision. The appealing party must send us the appeal no later than 30 calendar days after the date of this letter.

- **Written Appeal:** To submit a written appeal, mail or fax the written appeal to the address or fax number listed above**.**
- **Oral Appeal:** To file an oral appeal, call the following toll-free number: 877-897-4328.

There are three types of appeals:

- **Standard Appeal:** An appeal that does not involve urgent care such as emergency care, life-threatening conditions, or continued hospitalization.
- **Expedited Appeal:** An expedited appeal is available for emergency care, life-threatening conditions, and hospitalized members. An expedited appeal is also available for denials of prescription drugs and intravenous infusions for which the member is currently receiving benefits.
- **Acquired Brain Injury Appeal (this type of appeal may not be applicable in your case):** An appeal of denied services concerning an acquired brain injury.

Appeal Acknowledgment: Within five working days of receipt of the appeal, we will send the appealing party a letter acknowledging the date that we received the appeal and a list of documents that we may need for the appeal. If the appeal is oral, we will send the appealing party a one-page appeal form. The appealing party does not have to return the appeal form but we encourage its return because the form will help us resolve the appeal.

Our deadlines to resolve the appeal and send a written decision to the member or someone acting on the member's behalf and the provider of record are:

- **Standard Appeal:** 30 calendar days of receipt of the appeal
- **Expedited Appeal:** One working day from the date we receive all information necessary to complete the appeal. We may provide the determination by telephone or electronic transmission, but will provide a written determination within three working days of the initial telephonic or electronic notification.
- **Retrospective (claim) Appeal**: 30 calendar days after receipt of appeal. However, we may extend this deadline once for a period not to exceed 15 days.
- **Acquired Brain Injury Appeal (this type of appeal may not be applicable in your case)**: Not later than three business days after the date on which the individual submits the appeal. The notification of the determination must be provided through a direct telephone contact to the individual making the request. We will provide a written determination within 30 calendar days of receipt of the appeal.

Life-Threatening Conditions: If the patient has a life-threatening condition or receives a denial for prescription drugs or intravenous infusions for which they are currently receiving benefits, the patient, or someone acting on the patient's behalf, and the provider of record can request an immediate review by an independent review

organization (IRO) and is not required to follow our internal appeal procedures. See below for more information about the independent review.

After our internal review of your appeal, we will send a written decision, including:

- A statement of the specific medical, dental, or contractual reasons for the resolution;
- The clinical basis for the decision
- A description of or the source of the screening criteria that were utilized in making the determination
- The professional specialty of the provider who made the determination
- Notice of the appealing party's right to seek review of the adverse determination by an IRO under 28 TAC 19.1717
- A copy of a request for a review by an IRO form;
- Procedures for filing a complaint as described in 28 TAC 19.1705 (f).

Exhaustion of Internal Appeals: We will not require exhaustion of our internal appeals process if: (a) we fail to meet our internal appeal process timelines, or (b) the claimant with an urgent care situation files an external review before exhausting our internal appeal process, or (c) we decide to waive the appeal process requirements.

B. Independent Review

If we deny the appeal (continue to deny the services or treatment described above), the member or someone acting on the member's behalf and the provider of record have the right to request a review by an IRO. The IRO does not have an affiliation with your payor (insurance company or health plan), your health care providers, or the URA. To request the independent review, fill out the enclosed form and return it to the address or fax number listed in Section III above. The patient, parent, or the patient's legal guardian must sign the consent to release medical information to the IRO (included as part of the IRO form). We will notify the Texas Department of Insurance of the request for an Independent Review within one working day from the date the IRO request is received. The Texas Department of Insurance will randomly assign an IRO to review the matter. We will provide all required information to the IRO within three working days after the date we receive a request for IRO review. We will bear the costs of the Independent Review and will comply with their benefit decisions.

V. Complaint Procedures

The enrollee, an individual acting on behalf of the enrollee, or the provider of record may file an oral or a written complaint regarding our utilization review process or procedures by using the contact information listed above. We will respond to your complaint within 30 calendar days.

You always have the right to file a complaint with the Texas Department of Insurance

P.O. Box 12030
Austin, TX 78711-2030
Web: http://www.tdi.texas.gov
Toll Free: 1-800- 252-3439
Fax: 512- 490-1007

TDI | Texas Department of Insurance

LHL009 | 0522

Request for a Review by an Independent Review Organization (IRO)

Instructions to patient, person acting on behalf or representative of patient / employee, and provider

This form is being provided to you because your request for health care services has been denied as not medically necessary by your insurance carrier. You can now request that your case be reviewed by a health care provider who is totally independent of your health plan or insurance carrier (company). This is called an independent review by an Independent Review Organization or "IRO." You, your health care provider, or someone acting on your behalf or representative may file this form.

To request an independent review of your case, you must take the following action

- Complete the Request for a Review by an IRO form (TDI form LHL009).
- Sign the form so the IRO can receive your medical records. (A signature is not required for Workers' Compensation cases).
- Return the completed form to the company that is denying your request for health care services as soon as possible. Do not return this form to the Texas Department of Insurance (TDI). For Workers' Compensation cases, you must return this form within 45 calendar days.
    - Carrier instructions: Complete the "Company or URA That Denied Services" Section on page 4.
    - Note to patients: The company address and/or fax number can be found on the denial letter.
- The company will forward your request for an independent review to TDI. Once TDI receives the request from the company, TDI will assign your case to an IRO. You will receive a letter from TDI identifying the IRO to whom your case has been assigned.
- There is no cost to you for the independent review. Exception for Workers' Compensation Non-Network only: A health care provider requesting a retrospective independent review will be required to pay the IRO fee prior to the IRO beginningits review. However, if the IRO finds in favor of the health care provider, the health care provider will be reimbursed by the insurance carrier for the amount of the IRO fee.

The timeframes for an IRO's decision are as follows:

Coverage Types	Health	Workers' Compensation Network (WCN)	Workers' Compensation Non-Network (WC)
Life threatening	3 days	8 days	8 days
Denial of prescription drugs or intravenous infusions - Concurrent	3 days	NA	NA
Denial of an exception request to a prescription drug step therapy protocol - Preauthorization	3 days	NA	NA
Non-life-threatening Preauthorization / Concurrent	20 days	20 days	20 days
Retrospective	20 days	30 days from receipt of fee*	30 days from receipt of fee**

*Carrier pays the fee.

**Requestor pays the fee; however, if the requestor is an injured employee, carrier pays the fee.

Request information

Today's date (MM/DD/YYYY) _____ Name of requestor _____

Relationship to the patient or injured employee: (check one)

- ☐ Self (complete page 3, item A)
- ☐ Person acting on behalf of patient or injured employee (complete page 3, items A and C)
- ☐ Provider acting on behalf of patient or injured employee (complete page 3, items A and B)
- ☐ Provider that received the denial (complete page 3, item A)
- ☐ Sub claimant (Workers' Compensation only) (complete page 3, items A and C)

Applies to health and workers' compensation cases:

1. Is the condition life-threatening?

   ☐ Yes ☐ No

2. Is the review ordered by a Court? (This question does not apply if services have been received)

   ☐ Yes ☐ No

Applies to health cases **only**:

1. Is this a denial of prescription drugs or intravenous infusions for which you are already receiving benefits?

   ☐ Yes ☐ No

2. Is this a denial of an exception request to a prescription drug step therapy protocol?

   ☐ Yes ☐ No

Denied services - describe the health care services that are being denied and include dates only if services have been performed:

_____

_____

_____

_____

Patient / injured employee information

Health plan or claim identification number _____

(Usually found on the patient's ID card for health plans. The number identifies the patient to the insurance carrier. Enter the DWC claim number for workers' compensation cases.)

Date of birth (MM/DD/YYYY) _____ Sex _____

Name _____

Address _____

City _____ State _____ ZIP _____

Phone _____ FAX _____

Email _____

A. Provider that received the denial

Name _____

Federal tax identification number _____

Address _____

City _____ State _____ ZIP _____

Phone _____ FAX _____

B. Provider acting on patient's / injured employee's behalf if applicable

Name _____

Federal tax identification number _____

Address _____

City _____ State _____ ZIP _____

Phone _____ FAX _____

C. Person acting on patient's / injured employee's behalf if applicable

Name _____

Federal tax identification number _____

Address _____

City _____ State _____ ZIP _____

Phone _____ FAX _____

Release

The release must be signed by the patient, or his or her parent or legal guardian. Not required for Workers' Compensation cases.

I, _____ (Print name), ☐ the patient, ☐ parent, or ☐ patient's legal guardian **(select one)**, authorize the release to the Independent Review Organization of all necessary medical records and other documents that are relevant to the review and are in the possession of the Utilization Review Agent or any physician, hospital, or other health care provider.

Signed _____ Date (MM/DD/YYYY) _____

Note: For chemical dependency or mental health treatment, list the providers to which this release applies:

_____

_____

_____

Company or Utilization Review Agent that denied services

This section to be completed **only** by the company or URA that denied services. The person requesting the independent review should submit this form to the company given in this section.

Name of Company _____

Address _____

City _____ State _____ ZIP _____

Phone _____ FAX _____

Questions

For information about the independent review process, please call TDI at 1-866-554-4926, option 2. Reminder to return this from to the company that is denying your request for health care services. Do not return this form to the Texas Department of Insurance.

Your rights

You can request information we have about you by emailing OpenRecords@tdi.texas.gov or writing to: Public Information Coordinator, Texas Department of Insurance, P.O. Box 12030 (mail code GC-ORO) Austin, Texas 78711-2030. You also have the right to ask that we fix information we have about you that is wrong. To ask for a correction, send (1) your name, mailing address, and your phone number, (2) details about what needs to be fixed, and (3) the reason or proof showing why the information is wrong. Send this by email to RecordCorrections@tdi.texas.gov or by mail to: Record Correction Request, Texas Department of Insurance, P.O. Box 12030 (mail code CO-AAL-CC), Austin, Texas 78711-2030.