Provider Network News

PCHP Provider Claim Appeal Process: Process Change Effective May 1, 2024

Key Details

Effective May 1, 2024, PCHP's Provider Claim Appeal process is changing. The existing claims reconsideration and payment dispute process is being removed and integrated as a Level I Claim Appeal. All initial claim appeals are to be filed as a Level I Claim Appeal. If you disagree with the outcome of the original appeal, you may submit a Level II Claim Appeal.

Level I Claim Appeal: The first available option in the PCHP claim appeal process is called the Level I Claim Appeal. This is your first request to investigate the outcome of a finalized claim. Please note: we cannot process a claim appeal without a finalized claim on file.

Level II Claim Appeal: If you are dissatisfied with the outcome of a Level I Claim Appeal, you may submit a Level II Claim Appeal.

Provider Claim Appeal Summary

A claim appeal is when a claim is finalized, but a provider disagrees with the outcome and requests a review of the outcome. If a provider disagrees with the outcome of a final claim determination, an appeal may be filed within 120 calendar days from the date on the Explanation of Payment (EOP).

A claim appeal may be submitted for multiple reason(s), including:

- Contractual payment.
- Disagreements over reduced or zero-paid claims.
- Other health insurance denial.
- Claim code editing.
- Duplicate claim.
- Retro-eligibility.
- Experimental/investigational procedure.
- Claim data.
- Timely filing.*

There are three common, claim-related issues that are not considered claim appeals.

1. **Claim inquiry:** a question about a claim, but not a request to change a claim determination
2. **Claims correspondence:** when Parkland requests further information to finalize a claim; typically includes needing medical records, itemized bills, or information about other insurance a member may have
3. **Member medical necessity appeals:** a pre-service appeal for a denied service

* PCHP will consider reimbursement of a claim that has been denied due to failure to meet timely filing if:

1. Documentation is provided to prove the claim was submitted within the timely filing requirements as defined in the provider manual or
2. Demonstration that good cause exists

Note: A claim appeal cannot be reviewed and processed without the claim being finalized.

Level I Claim Appeal

The initial PCHP claim appeal is called the *Level I Claim Appeal*. This is the first request made by a provider to review and investigate the outcome of a finalized claim.

Level I Claim Appeals filed more than 120 calendar days from the Explanation of Payment (EOP) will be considered untimely and denied unless good cause can be established. A Level I Claim Appeal can be made in writing or online through our provider portal within 120 calendar days from the date on the EOP.

Claim Appeal Submission: When submitting a claim appeal, include as much supporting documentation and information as you can to help PCHP understand why you think the claim was not paid as you would expect.

1. PCHP Provider Portal
2. By Mail: Complete the Claim Appeal Request Form and submit to:

   Parkland Community Health Plan
   Claims Appeals and Complaints
   P.O. Box 560347
   Dallas, TX 75356-9005

PCHP will resolve the claim payment appeal within 30 calendar days of receipt. The status of an appeal can be viewed on the PCHP Provider Portal or by calling PCHP Provider Customer Service. Once an appeal is finalized, a determination letter will be mailed and a copy will be accessible on the PCHP Provider Portal. The determination letter will include:

- A statement of the provider's appeal request.
- A statement of what action PCHP intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes, or provider manual references.
- An explanation of the provider's right to request a Level II Claim Appeal within 30 calendar days of the date of the Level I Claim Appeal determination letter.
- How to submit a Level II Claim Appeal.

If the decision results in a claim adjustment, any payment adjustments and the EOP will be sent separately.

Level II Claim Appeal

If you disagree with the outcome of a Level I Claim Appeal, you may submit a *Level II Claim Appeal*.

A Level II Claim Appeal can be submitted on the PCHP Provider Portal or in writing and must be received by PCHP within 30 calendar days from the date on the Level I Claim Appeal determination letter.

When submitting a Level II Claim Appeal, include as much supporting documentation and information as you can to help PCHP understand the reason for disagreement with the Level I Claim Appeal determination. In addition, please include a copy of the Level I Claim Appeal denial letter. If a Level II Claim Appeal is submitted, but there is no history of a Level I Appeal, PCHP will default to a Level I Appeal.

Parkland will resolve the claim payment appeal within 30 calendar days of receipt. The status of an appeal can be viewed on the PCHP Provider Portal or by calling PCHP Provider Customer Service. Once an appeal is finalized, a determination letter will be mailed and a copy will be accessible on the PCHP Provider Portal. The determination letter will include:

- A statement of the provider's appeal request.
- A statement of what action PCHP intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes, or provider manual references.

If the decision results in a claim adjustment, any payment and the EOP will be sent separately.

Following the final determination of the Level II claim appeal, the Provider has exhausted the PCHP appeal process. If the provider is not satisfied with the resolution of the Level I and/or Level II claim appeal determination by PCHP and believes that they have not been given full due process, the provider may file a complaint with the Texas Health and Human Services Commission (HHSC) for STAR members or the Texas Department of Insurance (TDI) for CHIP members. A complaint should contain a written explanation of the provider's position on the issue and be accompanied by all materials related to the complaint including medical records and the written response(s) from PCHP.

Medicaid (STAR) complaints may be sent to:

Texas Health and Human Services Commission
Medicaid/CHIP Health Plan Management
Mail Code H-320
P.O. Box 85200
4900 N. Lamar
Austin, TX 78708-5200

or

Website: https://texashhs.org/ManagedCareProviderComplaint

Email: HPM_Complaints@hhsc.state.tx.us

CHIP provider complaints are submitted to the Texas Department of Insurance (TDI) rather than HHSC. The address is:

Texas Department of Insurance Consumer Protection
PO Box 12030 – MC-CO-CPS
Austin TX 78711-2030

Fax: 512-475-1771

Website: https://www.tdi.texas.gov/consumer/health-complaints.html

Email: ConsumerProtection@tdi.state.tx.us

No Retaliation
Parkland Community Health Plan will not retaliate against any person filing a complaint against the health plan or appealing a decision made by the health plan.