



Parkland
Community Health Plan, Inc.

[TEMPLATE.DatePrint]

[TEMPLATE.ConvertedMemName]
[TEMPLATE.Mem Addr 1], [TEMPLATE.Mem Addr2]
[TEMPLATE.Mem City, State Zip]

Subject: Prior Authorization Request for Parkland KIDS*first* Member

Member Name: [TEMPLATE.MemName]
Member ID: [TEMPLATE.MemID]
Requesting Provider: [TEMPLATE.ReferFromName]
Date Request Received: [TEMPLATE.ReceiptDate]
Requested Service: [TEMPLATE.FreeFormText]
Requested Date(s) of Service: [TEMPLATE.EffDate] to [TEMPLATE.FreeFormText]
Authorization Number: [TEMPLATE.AuthorizationID]

Dear Parkland KIDS*first* Member:

We would like to inform you (member or an individual acting on behalf of the member, and the member's provider of record, including the health care provider who rendered the service) of our decision about this request. A physician looked at all of the records that were sent to us. We also tried to talk to your physician about the request. Any new information given to us was considered. The physician who made the decision is Board Certified in [TEMPLATE.FreeFormText]

Decision

The request for [TEMPLATE.FreeFormText] is [TEMPLATE.TemplateType].

The facts do not show that the services are needed to treat your condition. The reason for this decision is:

[TEMPLATE.MedDirClinicalNotes]

Guideline(s) used in making this decision

We use national and/or plan guidelines to help us make our decisions. In this case the criteria we used [TEMPLATE.FreeFormText].

You can ask for a free copy of the guideline(s). Call the Parkland KIDS*first* Member Advocate at the number below and we will send you a copy within ten (10) working days.

The physician who made the request has been told about this decision. The date the decision will take effect is [TEMPLATE.DenialEff Date]. If you are asking to continue care we have approved before, this is the last day the care will be approved.

A copy of this letter has been sent to your primary care provider and other providers, if needed. You should call your primary care provider to help you with any future requests for health care services.

Internal Appeal Process

The enrollee or someone acting on the enrollee's behalf and the provider of record have the right to appeal this adverse determination orally or in writing. A physician who has not previously reviewed the case will make the appeal decision. The appealing party must send us the appeal no later than 60 days after the date of this letter.

- **Written Appeal:** To submit a written appeal, mail or fax the written appeal to the **Parkland Community Health Plan** Attn: Member Advocates at P.O. Box 569005 Dallas, Texas 75356-9005 or Fax 1-877-223-4580.
- **Oral Appeal:** To file an oral appeal, call the following toll-free numbers: 1-888-814-2352

There are four 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 enrollees. An expedited appeal is also available for denials of prescription drugs and intravenous infusions for which the enrollee is receiving benefits.
- **Specialty Appeal:** The appeal is available *only* after we decide the initial appeal. Please see below for more informational.
- **Acquired Brain Injury Appeal:** An appeal of denied services concerning an acquired brain injury.

Appeal Acknowledgement: 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 enrollee or someone acting on the enrollee's behalf and the provider of record are:

- **Standard Appeal:** 60 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:** 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.

Specialty Appeal: If we deny the appeal, the provider of record may request a specialty appeal, which requests that a specific type of specialty review the case. The provider must request this type of appeal in writing within 10 working days from the denial and must show good cause for the specialty appeal. We will complete the specialty appeal and send our written decision to the enrollee or the person acting on the enrollee's behalf and the provider within 15 working days of receipt of the request for the specialty 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 already receiving benefits the patient or someone acting on the enrollee'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 IRO review.

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 (life-threatening condition) files an external review before exhausting our internal appeal process or (c) per discussion with the Center for Consumer Information and Insurance Oversight (CCICO).

Independent Review

If we deny the appeal (continue to deny the services or treatment described above), the enrollee or someone acting on the enrollee's behalf and the provider of record have a right to request a Standard External Review through MAXIMUS within 4 months after the date of this

notification. The External Review Process does not have an affiliation with Parkland Community Health Plan, or your healthcare providers.

To request the Standard External Review, complete the HHS Federal External Review Request Form enclosed. Mail or fax the form along with this letter directly to MAXIMUS at:

MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534
Fax number: 1-888-866-6190

Or you can submit your request online at externalappeal.com under the “Request a Review Online” heading.

Expedited IRO

You (member or an individual acting on behalf of the member, or member’s provider of record) can ask that the External Review of your appeal be handled right away, if you think waiting for a decision would cause you harm.

To ask for an expedited external review:

- You can e-mail the request to FERP@maximus.com
- Call the Federal External review Process at 888-866-6205 ext 3326 or
- Selecting “expedited” when submitting the review request online

In urgent care situations, MAXIMUS Federal Services will accept a request for external review from a medical professional who knows about the claimant’s condition. The medical professional will not be required to submit proof of authorization.

Complaint Procedures

You can send a complaint to us (Parkland KIDSfirst Health Plan): Enrollees, individuals acting on behalf of enrollees, and health care providers may file a written or oral complaint about our utilization review process or procedures. Use the telephone numbers and address referenced above to file your oral or written complaint. We will respond to your complaint in writing within 30 days.

Complaints to TDI (Texas Department of Insurance): A complainant also has the right to file a complaint with TDI by contacting TDI at the following address, telephone numbers, or website:

Texas Department of Insurance
P.O. Box 149091
Austin, TX 78714-9091
Telephone: 1-800-252-3439

Parkland Community Health Plan
P O Box 569005 | Dallas, TX 75356-9005
KIDSfirst/CHIP 1.888.814.2352 | Fax 1.800.240.1131

009-MM-AD-02-031717

Revised: 12/28/2018

Fax: 1-512-490-1007

Online: <http://www.tdi.texas.gov/general/>

If you need help getting care, please call us and ask to speak to the Parkland KIDS*first* Member Advocate at **1-888-814-2352-**

Sincerely,

[TEMPLATE.MMA Init]

Medical Management Department
Parkland Community Health Plan

Enclosure(s):
HHS Federal External Review Request Form
Nondiscrimination Notice

cc: [TEMPLATE.ReferFromName]

cc: [TEMPLATE.ReferToName]

cc: [Template.PCPName]

cc: [TEMPLATE.OtherMail]

cc: [TEMPLATE.OtherFax]

Parkland Community Health Plan
P O Box 569005 | Dallas, TX 75356-9005
KIDS*first*/CHIP 1.888.814.2352 | Fax 1.800.240.1131

009-MM-AD-02-031717

Revised: 12/28/2018

Parkland Community Health Plan
P O Box 569005 | Dallas, TX 75356-9005
KIDS*first*/CHIP 1.888.814.2352 | Fax 1.800.240.1131

009-MM-AD-02-031717

Revised: 12/28/2018