UnitedHealthcare Community Plan

Grievance and Appeal Process

Important Terms

An **adverse benefit determination** is the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

An adverse benefit determination includes:

- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- The failure to provide services timely as defined in the appointment standards
- The failure of the health plan to act within the timeframes provided in 42 C.F.R. § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals

For a resident of a rural area with only one Managed Care Organization, the denial of a member's request to exercise his or her right, under § 42 C.F. R. 438.52(b)(2)(ii), to obtain services outside the network:

- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities; and
- Determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of Section 1919(e)(7) of the Act, if applicable

A **complaint** is an expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) calendar day of receipt. You must submit a complaint in writing or over the phone **within 30 calendar days** of the event causing dissatisfaction. You, your provider or an authorized representative acting on your behalf may file a complaint.

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Grievance process

A **grievance** is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to:

- Quality of care or services provided
- Rudeness of a provider or employee
- Failure to respect the member's rights

You, your provider acting on your behalf or other authorized representative acting on your behalf can file a grievance at any time. If you call us, we will let you know we've received your grievance unless you ask us to confirm receipt in writing. If you write to us, we will send you a letter within five (5) calendar days telling you we received your grievance. We will review your grievance and send notice of our decision within thirty (30) calendar days of receiving your grievance or expeditiously as your health condition requires. If you ask for more time or we need more information and the delay is in your interest, the time frame may be extended by up to 14 days. If we ask for more time, we will try to call you and we will write you to let you know why we need more time.

To file a grievance

Call Member Services at
1-877-743-8731, TTY **711**

Or write us at:
UnitedHealthcare Community Plan
Attention: Appeals and Grievance
P.O. Box 31364
Salt Lake City, UT 84131-0364

If you need help with your grievance, please call Member Services at
1-877-743-8731, TTY **711**

7:30 a.m.–5:30 p.m. CT, Monday–Friday

7:30 a.m.–8:00 p.m. CT, Wednesday

8:00 a.m.–5:00 p.m. CT, the first Saturday and Sunday of each month.

Use the form below or in the member handbook to file a grievance. We must have your written permission if your provider, family member or authorized representative will be filing a grievance on your behalf.

What can I do if I need a fast decision?

If you or someone acting on your behalf (provider, family member, authorized representative, etc.) wants a fast decision because your health is at risk, you may file an **Expedited Grievance** by calling member services at **1-877-743-8731,** TTY **711.**

UnitedHealthcare will call you with our decision within 72 hours of you asking for a fast decision. This time frame may be extended up to 14 days. If you ask for more time or we show that there is need for additional information and the delay is in your interest, the time frame may be extended. If we ask or an extension, we will give you written notice of the reason. You will receive a decision letter in writing. The letter will let you know the reason for our decision and what to do if you don't like the decision. If we decide that your grievance does not need a fast decision based on the rules, we will call you to let you know. Your grievance will be handled within 30 calendar days. We will also send you a letter telling you this within two (2) days of calling you. After your grievance is reviewed, we will send you a letter letting you know our decision.

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Appeal process

What is an appeal?

An appeal means you are requesting a review by UnitedHealthcare Community Plan of an Adverse Benefit Determination.

Members have a right to request appeal of an adverse benefit determination. **You, your provider, family member or other authorized representative acting on your behalf must file your appeal within 60 calendar days of receiving UnitedHealthcare's Notice of Adverse Benefit Determination.**

When you file an appeal, we will send you a letter within ten (10) calendar days telling you we received your appeal. We will review your appeal and send you our decision within thirty (30) calendar days. If you ask for more time or we show there is a need for more information and the delay is in your interest, the time frame may be extended up to 14 days. If we ask for more time, we make a reasonable attempt to call you and we send you a letter to let you know why we need more time.

If you have been getting medical care and your health plan reduces, suspends, or ends the service, you can appeal. In order for medical care not to stop while you appeal the decision, you must appeal within ten (10) calendar days from the date of the Notice of Adverse Benefit Determination and tell us not to stop the service while you appeal. If you do not win your appeal you may have to pay for the medical care you got during this time.

Your benefits will continue until one of the following occurs:

- You withdraw the appeal request
- You do not request an appeal within 10 calendar days from the date of the notice of adverse benefit determination
- The authorization for services has expired or service authorization limits are met
- An appeal decision is issued that is adverse to you

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Salt Lake City, UT 84131-0364

If you need help with your grievance, please call Member Services at
1-877-743-8731, TTY **711**

7:30 a.m.–5:30 p.m. CT, Monday–Friday

7:30 a.m.–8:00 p.m. CT, Wednesday

8:00 a.m.–5:00 p.m. CT, the first Saturday and Sunday of each month.

Members have the right to present additional information or review the appeal case file for an appeal.

Use the form below or in the member handbook to file an appeal. We must have your written permission if your provider, family member or authorized representative will be filing an appeal on your behalf.

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UnitedHealthcare will resolve an appeal and provide written notice of the resolution within 30 calendar days. UnitedHealthcare may extend this time frame by up to 14 calendar days upon a member's request or if UnitedHealthcare demonstrates the need for more information and that a delay in rendering the decision is in the member's best interest. For any extension not requested by the member, UnitedHealthcare will give the member written notice of the reason for delay.

What can I do if I need immediate care?

If you or your doctor wants a fast decision because your health is at risk, call Member Services at **1-877-743-8731,** TTY **711** for an expedited review of a Notice of Adverse Benefit Determination. You do not have to send a letter for a fast decision once you call Member Services. UnitedHealthcare Community Plan will call you with our decision within 72 hours of getting your request for an expedited review. This time frame may be extended up to 14 days if you ask for the extension or we show that there is need for additional information and the delay is in your interest. If we ask for an extension, we will make a reasonable attempt to call you and we send you a letter to let you know why we need more time. If we decide that your appeal does not need a fast decision based on the rules, we will call you. Your appeal will be handled within 30 calendar days. We will also send you a letter telling you this within two days of calling you. You will receive a letter telling the reason for our decision and what to do if you don't like the decision.

How do I file a State Fair Hearing request?

If you disagree with an adverse benefit determination by UnitedHealthcare Community Plan, you or someone acting on your behalf (provider, family member, etc.) can also appeal directly to the Mississippi Division of Medicaid (DOM) by filing a request for a State Fair Hearing.

You can appeal to DOM after you have exhausted your appeal rights with UnitedHealthcare Community Plan.

You must file for a State Fair Hearing within one hundred and twenty (120) calendar days of your receipt of the final decision from UnitedHealthcare Community Plan. For information on requesting a State Fair Hearing, call 601-359-6050 or 1-800-421-0488 or write to:

Division of Medicaid Office of the Governor
Attn: Office of Appeals 550 High Street, Suite 1000
Jackson, Mississippi 39201

Continuation of benefits

If you have been getting an ongoing service or item that is being reduced, changed or stopped, you may continue with it if:

1. Your appeal is received within 10 days from the date you receive UnitedHealthcare Community Plan's Notice of Adverse Benefit Determination
2. You request that the service be continued

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Grievance and Appeal Process

The service may be continued through the appeal and State Fair Hearing process unless you discontinue your appeal, fail to request a State Fair Hearing and continuation of benefits, or the prescription for your service ends. If you request a State Fair Hearing and want your benefits to continue, you must file your request within 10 days from the date you receive our decision. If the State Fair Hearing finds that UnitedHealthcare Community Plan's decision was right, you may be responsible for the cost of the continued benefits.

Additional protections for Mississippi Medicaid beneficiaries

Pursuant to federal law, state law and agency policy, the Mississippi Division of Medicaid further protects PHI that pertains to alcohol and drug abuse, HIV/AIDS, sexually transmitted diseases (STDs), mental health, genetic test results and family planning. Information in these categories requires written authorization before disclosure to someone outside Medicaid unless it is:

- For treatment for medical emergency
- Deidentified or the disclosure does not identify the beneficiary as possessing a sensitive data category
- For scientific research in certain circumstances
- For management and financial audits in certain circumstances
- For program evaluations in certain circumstances
- By court order, if appropriate
- If otherwise required by law
- To a personal representative (except in cases of minors — consent must be obtained from the minor before disclosing to parent, guardian or other legal representative)
- Internal agency communications for the purpose of the provision of diagnosis, treatment or referral for treatment
- To law enforcement regarding crimes or threats to commit crimes on premises or against personnel
- To entities that provide services to the agency (e.g., contractors and business associates)

Grievance and appeal form

Memeber Name: _____

ID#: _____ Date of request: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone (home): _____ (work): _____

Describe your concern in detail using names, dates, places of services, time of day and issues. If applicable, also say why UnitedHealthcare should consider payment for requested services that are not normally covered. Mail this form to the address at the bottom.

_____

_____

_____

_____

_____

_____

_____

_____

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Attention: Appeals and Grievance
P.O. Box 31364
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