2018 Administrative Guide

Physician, Health Care Professional, Facility and Ancillary

KanCare Program

Chapter 5: Member Grievances & Appeals

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UnitedHealthcare® Community Plan

Welcome to UnitedHealthcare Community Plan

Welcome to the Community Plan provider manual. This complete and up-to-date reference PDF (manual/guide) allows you and your staff to find important information such as processing a claim and prior authorization. This manual also includes important phone numbers and websites on the How to Contact Us page. Operational policy changes and other electronic tools are ready on our website at **UHCprovider.com**.

Click the following links to access different manuals:

- **UnitedHealthcare Administrative Guide** for Commercial and Medicare Advantage member information. Some states may also have Medicare Advantage information in their Community Plan manual.
- A different Community Plan manual – go to **UHCprovider.com/guides** > Community Plan Care Provider Manuals.

Easily find information in this manual using the following steps:

1. Select CTRL+F.
2. Type in the key word.
3. Press Enter.

If available, use the binoculars icon on the top right hand side of the PDF.

If you have any questions about the information or material in this manual or about any of our policies, please call Provider Services.

We greatly appreciate your participation in our program and the care you offer our members.

Important Information about the use of this manual

In the event of a conflict between your agreement and this care provider manual, the manual controls unless the agreement dictates otherwise. In the event of a conflict between your agreement, this manual and applicable federal and state statutes and regulations and/or state contracts, applicable federal and state statutes and regulations and/or state contracts will control. UnitedHealthcare Community Plan reserves the right to supplement this manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

We amend the manual as policies change.

Effective January 01, 2019, all care providers (participating and non-participating) are required to be enrolled with the State of Kansas (and obtain a KMAP ID) in order to receive payment from UnitedHealthcare Community Plan. Additionally, for non-participating care providers, a non-participating care provider reimbursement agreement will be required for each claim.

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Chapter 5: Member Grievances & Appeals

UnitedHealthcare Community Plan maintains a timely and organized process using established policies and procedures to ensure prompt resolution of grievances and appeals. UnitedHealthcare Community Plan has a specialized grievance and appeal department. We allocate qualified and trained personnel to establish, implement and maintain this process.

Our grievance and appeals system is HIPAA compliant and conforms to applicable federal and state laws, regulations and policies.

Upon enrollment, members receive written information which clearly explains the grievance system requirements. These member materials were developed in accordance with federal regulations and the State of Kansas regarding content, timing and translation of such information. They are provided in each prevalent non-English language occurring within each service area. Members are informed that grievance system information is available in prevalent non-English languages upon request, how to obtain it and via oral interpretation services in any language. You are informed of the member grievance and appeal process through the UnitedHealthcare Provider Manual and the provider portal of the UnitedHealthcare website. Materials are available in hard copy and on our Member website at **uhccommunityplan.com**.

The information includes a description of: the right to State Fair Hearing, the method for obtaining a State Fair Hearing, the rules that govern representation at the hearing, the right to file grievances, the requirements and time frames for filing grievances and appeals, the availability of assistance in the filing process, the toll-free numbers the member may use to file a grievance or appeal by phone, benefits will continue when requested by the member in an appeal or State Fair Hearing request concerning certain actions which are timely filed, the member may be required to pay the cost of services furnished during the appeal/hearing process if the final decision is adverse to the member, and you or appointed representative may file an appeal on behalf of a member with the member's written consent. A copy of the Authorized Representative Designation Form is found in the last page of this handbook.

5.1 Filing a Member Grievance

A grievance is an expression of dissatisfaction about a matter other than an adverse benefit determination, including quality of care or quality of service. Members, or their authorized representative, may file a grievance with us in the following ways:

By calling Member Services: (8 a.m. – 6 p.m. CT)	**877-542-9238** or TDD/TTY: 711
In writing by mailing your grievance to:	**UnitedHealthcare Community Plan - Kansas** **Attention: Appeals and Grievance** **P.O. Box 31364** **Salt Lake City, UT 84131-0364**
In person during normal business hours: (8 a.m. – 5 p.m. CT)	**UnitedHealthcare Community Plan - Kansas** **10895 Grandview Drive, Suite 200** **Overland Park, KS 66210**
Electronically:	**personalhealthmessagecenter.com/public/forms/KS-Grievance**

This information can also be found in the Member Handbook and on the UnitedHealthcare website. Welcome packet materials and the Member Handbook state you should file grievances directly with UnitedHealthcare Community Plan and encourage members to follow the grievance process appropriately. UnitedHealthcare Community Plan date stamps written grievances, enters them into the grievance tracking system and creates a case file. There is no timely filing limit to submit a grievance.

5.2 Process for Resolving a Grievance

Member Services receives calls 24 hours a day, seven days a week to address various issues, including member grievances. All calls related to member grievances are logged into UnitedHealthcare's Escalation Tracking System (ETS). The majority of member grievances are resolved during the initial call to UnitedHealthcare. The information is sorted to identify any potential quality of care issues. If a call pertains to a potential quality of care issue, the member grievance is handled by the Quality Management Department in accordance with all applicable quality management processes and procedures.

The Resolution Analyst conducts preliminary research to verify the appropriate path of the grievance. The Resolution Analyst will research and processes the grievance for resolution. If it is necessary to involve other departments, the Resolution Analyst triages the grievance to the appropriate department and oversees the process until resolution is attained. The Resolution Analyst will close the case file in ETS with all applicable data. Members generally receive notification of the grievance resolution within 30 calendar days, but no longer than 60 calendar days.

5.3 Member Appeal Process

When UnitedHealthcare Community Plan makes a decision to deny or issue a limited authorization of a service authorization request, or reduces, suspends or terminates a previously authorized service, we mail a Notice of Adverse Benefit Determination the member. You are also informed via written notice of the decision to deny or reduce a service authorization request. We will mail a notice of adverse benefit determination to the member as expeditiously as their health condition requires, but not later than 14 calendar days following the receipt of the authorization request with a possible extension of up to 14 calendar days if the member or you request an extension, or if we establish a need for additional information and the delay is in the member's best interest. In cases where a provider indicates or UnitedHealthcare Community Plan determines that following the standard time frame could seriously jeopardize the members life, physical or mental health or ability to attain, maintain or regain maximum function, UnitedHealthcare Community Plan will make an expedited authorization decision and provide a written notice of Adverse Benefit Determination no later than 72 hours after the receipt of the request for service. This may be extended by 14 calendar days if the member requests an extension or if UnitedHealthcare Community Plan shows a need for additional information and how the extension is in the member's interest.

5.4 Filing an Appeal

An individual (or a representative authorized in writing to act on the member's behalf) may file an appeal in response to the actions described above. The member has 60 calendar days (plus three calendar days will be allowed for mailing time) from the date of the notice of adverse benefit determination, to file an appeal. We accept member appeals in the following ways:

By calling Member Services:	**877-542-9238** or TDD/TTY: **711**
In writing by mailing your appeal to:	**UnitedHealthcare Community Plan - Kansas** **Attention: Appeals and Grievance** **P.O. Box 31364** **Salt Lake City, UT 84131-0364**
In person during normal business hours: (8 a.m. – 5 p.m. CT)	**UnitedHealthcare Community Plan - Kansas** **10895 Grandview Drive, Suite 200** **Overland Park, KS 66210**
Electronically:	**personalhealthmessagecenter.com/public/forms/KS-Appeal**

UnitedHealthcare Community Plan date stamps an appeal received, enters the pertinent information into the appeals tracking system and creates an appeal case file to include available and relevant information associated with the appeal. The appeals staff acknowledges the receipt of each member appeal within five calendar days for standard appeals and makes an effort to notify members verbally within one calendar day for cases accepted as expedited appeals. For verbally received appeals, United Healthcare Community Plan will attempt to obtain a written, signed appeal from the member; however, will process the appeal whether or not the member signs a written appeal.

5.5 Timeliness for Resolving an Appeal

UnitedHealthcare Community Plan will resolve standard appeals and appeals for termination, suspension, or reduction of previously authorized services within 30 calendar days after receipt of the appeal. UnitedHealthcare Community Plan will expedite resolution of an appeal if, according to the information provided by the member or as indicated by a provider filing an appeal on the member's behalf, the standard resolution time frame could seriously jeopardize the member's life, physical or mental health or ability to attain, maintain, or regain maximum function. Under such circumstances, we will resolve the expedited appeal within 72 hours. If the expedited appeal request is denied, the appeal will be transferred to the standard appeal process and will be resolved within 30 calendar days of the receipt date on the appeal. We make every effort to contact the member verbally to notify them of the denial and provide written notice of denial, including the member's right to file a grievance regarding our denial of a request for expedited resolution.

5.6 Process for Resolving an Appeal

After the appeal has been logged into the tracking system and the acknowledgment letter has been sent, the appeal is assigned to a Resolution Analyst. Member benefits continue until a decision is rendered:

- If Adverse Benefit Determination reduces, suspends or terminates previously authorized waiver services, those services will continue for 60 calendar days plus three calendar days from the date of the notice of adverse benefit determination, to allow time to file an appeal. This applies to waiver benefits/beneficiaries only.

- If the member or their authorized representative files an appeal for non-waiver benefits within 10 calendar days from the date the adverse benefit determination is sent, and the member requests continuation of benefits, and services were ordered by an authorized care provider, the current non-waiver services will continue for the duration of the appeal.

No punitive action is taken against a care provider who either requests an expedited resolution or supports a member's appeal. Any information received during the resolution process is date stamped and incorporated into the case file. For clinical appeals, the Resolution Analyst assembles relevant background information from UnitedHealthcare's prior authorization and claims systems, obtains relevant clinical information and forwards the matter to a health care professional with clinical expertise in treating the enrollee's condition or disease that was not involved in any decision-making or previous review surrounding the action or appeal.

If the matter requires review by another UnitedHealthcare department, the Resolution Analyst requests a designated subject matter expert in the department address specific issues necessary to resolve the appeal. The Resolution Analyst may contact the member or the member's treating provider to obtain information necessary to resolve the appeal. Upon completion of this process, the Resolution Analyst or designee provides verbal notice of our decision for an expedited resolution and issues a written Notice of Appeal Resolution for both expedited and standard resolutions.

The Notice of Appeal Resolution contains the date of resolution, reasons for the determination in easily understood language, and a written statement of the clinical rationale for the decision, including how you or enrollee may obtain the decision making criteria. For appeals not resolved wholly in favor of the member, the Notice of Appeal Resolution will include:

(1) The member's right to request a fair hearing (including the requirement that the member must complete the UnitedHealthcare Community Plan appeal process before requesting a state fair hearing and that the member must file the request for a hearing no later than 120 plus three calendar days from the date of the Notice of Appeal Resolution and how to make the request;

(2) Include information on the enrollee's right to receive services while the hearing is pending and how to make the request.

5.7 Request for State Fair Hearing

State Fair Hearing: Members, or their authorized representatives, may ask the Kansas Office of Administrative Hearings (OAH) to review the outcome of an appeal decision made by UnitedHealthcare Community Plan if there is a disagreement with the appeal outcome. State Fair Hearing requests must be submitted to the OAH no later than 120 calendar days (plus three calendar days will be allowed for mailing time) from the date of the Notice of Appeal Resolution.

- Members may only request a State Fair Hearing after completion of the UnitedHealthcare Community Plan appeal process. The Kansas Office of Administrative Hearings must receive the request for a State Fair Hearing within 123 calendar days after the date of the United Healthcare's response letter advising of the outcome of the appeal.

- A State Fair Hearing can be requested in the following ways:

  1. Call UnitedHealthcare at 877-542-9238.

  2. Electronically via Office of Administrative Hearings fax: 785-296-4848.

  3. Complete the Request for Administrative Hearing form found online at **oah.ks.gov/Home/Forms** and mail it to:

     Office of Administrative Hearings
     1020 S. Kansas Avenue
     Topeka, KS 666124

  4. Or, In Person:

     10895 Grandview Drive, Suite 200
     Overland Park, KS 66210
     (During business hours 8 a.m. – 5 p.m. CT)

5.8 Processes Related to Reversal of UnitedHealthcare's Initial Decision

If UnitedHealthcare Community Plan or the Office of Administrative Hearings (OAH) reverses a decision to deny, limit, or delay services not provided while the appeal was pending, we will authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires. If the decision reverses a decision to deny authorization of services and the disputed services were received pending appeal, we will pay for those services as specified in policy and/or regulation.

5.9 Authorized Representative Designation Form

Appointment of Representative Form

You can choose to have a representative help you with your Appeal or Grievance. This form allows you to name the person who will be your representative.

The top part of the form needs to be filled out by you. If you are not able to fill it out your representative may fill it out for you.

Member Name _____ **Member ID** _____

I want _____ to be my
(Please print the name of person whom you want as your representative.)
representative for this Appeal or Grievance.

My representative may do all of the things below on my behalf for this Appeal or Grievance:

— Make or give any request or notice.

— Present, gather or give any information.

— Receive any notices or requests for information.

I also allow UnitedHealthcare Community Plan to release and discuss my personal health information with the person named above during my appeal.

Member Signature _____ **Date** _____

Representative Name _____ **Telephone Number** _____

Representative Signature _____ **Date** _____