Chapter 12: Claim Reconsiderations, Appeals and Grievances

There are a number of ways to work with us to resolve claims issues or disputes. We base these processes on state and federal regulatory requirements and your provider contract.

The following grid lists the types of disputes and processes that apply:

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS								
SITUATION	**DEFINITION**	**WHO MAY SUBMIT?**	**SUBMISSION ADDRESS**	**ONLINE FORM FOR FAX OR MAIL**	**CONTACT PHONE NUMBER/ FAX**	**WEBSITE (Care Providers Only) for Online Submissions**	**CARE PROVIDER FILING TIMEFRAME**	**UnitedHealthcare Community Plan RESPONSE TIMEFRAME**
Care Provider Claim Resubmission	Creating a new claim. If a claim was denied and you resubmit the claim (as if it were a new claim), then you will normally receive a duplicate claim rejection on your resubmission.	Care Provider		**UHCprovider.com/claims**	800-600-9007	Use the Claims Management or ClaimsLink application on Link. To access Link, go to **UHCprovider.com/link**.	Within 60 days of remittance	
Care Provider Claim Reconsideration (step 1 of claim dispute)	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.	Care Provider	UnitedHealthcare Community Plan P.O. Box 8207 Kingston, NY 12402	**UHCprovider.com/claims**	800-600-9007 Fax: 801-994-1224	Use the Claims Management or ClaimsLink application on Link. To access Link, go to **UHCprovider.com/link**.	Timeframe listed in your contract	30 calendar days

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APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS

SITUATION	DEFINITION	WHO MAY SUBMIT?	SUBMISSION ADDRESS	ONLINE FORM FOR FAX OR MAIL	CONTACT PHONE NUMBER/ FAX	WEBSITE (Care Providers Only) for Online Submissions	CARE PROVIDER FILING TIMEFRAME	UnitedHealthcare Community Plan RESPONSE TIMEFRAME
Care Provider Claim Formal Appeal (step 2 of claim dispute)	A second review in which you did not agree with the outcome of the reconsideration.	Care Provider	UnitedHealthcare Community Plan of Pennsylvania P.O. Box 31364 Salt Lake City, UT 84131-0364	UHC provider. com/ claims	800-600-9007	Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider. com/link.	Timeframe listed in your contract	30 to 60 calendar days
Care Provider Grievance	A complaint expressing dissatisfaction with operations, activities, or behavior of a health plan or member	Care Provider		UHC provider. com/ claims	800-600-9007	Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider. com/link.	Timeframe listed in your contract	30 to 60 calendar days

The above definitions and process requirements are subject to modification by state contract or regulations. States may impose more stringent requirements.

UnitedHealthcare Community Plan and its contracted providers may agree to more stringent requirements within provider contracts than described in the standard process.

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Denial

Your claim may be denied for administrative or medical necessity reasons.

An **Administrative denial** is when we didn't get notification before the service, or the notification came in too late.

Denial for **medical necessity** means the level of care billed wasn't approved as medically necessary.

If a claim is denied for these reasons, you may be able to request a claim reconsideration or file an appeal.

Other top reasons for denial include:

Duplicate claim – This is one of the most common reasons for denial. It means resubmitting the same claim information. This can reset the clock on the time it takes to pay a claim.

Claim lacks information. Basic information is missing, such as a person's date of birth; or information incorrect, such as spelling of a name. You can resubmit this type of claim with the correct information.

Eligibility expired. Most practices verify coverage beforehand to avoid issues, but sometimes that doesn't happen. One of the most common claim denials involving verification is when a patient's health insurance coverage has expired and the patient and practice were unaware. Also, in a lot of cases, practices may check eligibility when an appointment is made, but between the appointment being made and the actual visit, coverage can be dropped. We recommend an eligibility check again once the patient has arrived.

Claim not covered by UnitedHealthcare Community Plan. Another claim denial you can avoid is when procedures are not covered by us. You can easily avoid this problem by using real-time verification.

Time limit expired. This is when you don't send the claim in time.

Claim Correction

What is it?

A corrected claim replaces a previously denied submitted claim due to an error. A denied claim has been through claim processing and determined it can't be paid.

When to use:

Submit a corrected claim to fix one that has already processed.

How to use:

Use the claims reconsideration application on Link. To access Link, sign in to **UHCprovider.com** using your Optum ID. You may also submit the claim by mail with a claim reconsideration request form. Allow up to 30 days to receive payment for initial claims and a response.

Mailing address:

UnitedHealthcare Community Plan
P.O. Box 5240
Kingston, NY 12402-5240

Additional Information:

When correcting or submitting late charges on 837 institution claims, use bill type xx7: Replacement of Prior Claim. Do not submit corrected or additional information charges using bill type xx5: Late Charge Claim.

Resubmitting a Claim

What is it?

When you resubmit a claim, you create a new claim in place of a rejected one. A rejected claim has not been processed due to problems detected before processing.

When to use it:

Resubmit the claim if it was rejected. A rejected claim is one that has not been processed due to problems detected before claim processing. Since rejected claims have not been processed yet, there is no appeal - the claim needs to be corrected through resubmission.

Common Reasons for Rejected Claims:

Some of the common causes of claim rejections happen due to:

- Errors in member demographic data – name, age, date of birth, sex or address.
- Errors in care provider data.
- Wrong member insurance ID.
- No referring care provider ID or NPI number.

How to use:

To resubmit the claim, follow the same submission instructions as a new claim. To mail your resubmission, provide all claim information to:

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UnitedHealthcare Community Plan
P.O. Box 5240
Kingston, NY 12402-5240

Warning! If your claim was denied and you resubmit it, you will receive a **duplicate claim rejection**. A denied claim has been through claim processing and we determined it cannot be paid. You may appeal a denied claim by submitting the corrected claim information or appealing the decision. See Claim Correction and Reconsideration sections of this chapter for more information.

Claim Reconsideration (step one of dispute)

What is it?

Claim issues include overpayment, underpayment, denial, or an original or corrected claim determination you do not agree with. A claim reconsideration request is the quickest way to address your concern about whether the claim was paid correctly.

When to use:

Submit a claim reconsideration when you think a claim has not been properly processed.

For administrative denials:

- In your reconsideration request, please ask for a medical necessity review and include all relevant medical records.

For medical necessity denials:

- In your request, please include any additional clinical information that may not have been reviewed with your original claim.
- Show how specific information in the medical record supports the medical necessity of the level of care performed – for example, inpatient instead of observation.

How to use:

If you disagree with a claim determination, submit a claim reconsideration request electronically, by phone, mail or fax:

- **Electronically:** Use the Claim Reconsideration application on Link. Include electronic attachments. You may also check your status using Link.
- **Phone:** Call Provider Services at **800-600-9007** or use the number on the back of the member's ID card. The tracking number will begin with SF and be followed by 18 numbers.
- Mail: Submit the Claim Reconsideration Request Form to:

  UnitedHealthcare Community Plan
  P.O. Box 5240
  Kingston, NY 12402-5240

  This form is available at **UHCprovider.com**.
- Fax: Send the Claim Reconsideration Request Form to **801-994-1224**.

Valid Proof of Timely Filing Documentation (Reconsideration)

What is it?

Proof of timely filing occurs when the member gives incorrect insurance information at the time of service. It includes:

- A denial or rejection letter from another insurance carrier.
- Another insurance carrier's explanation of benefits.
- Letter from another insurance carrier or employer group indicating:
  - Coverage termination prior to the date of service of the claim
  - No coverage for the member on the date of service of the claim

A submission report is not proof of timely filing for electronic claims. It must be accompanied by an acceptance report. Timely filing denials are often upheld due to incomplete or wrong documentation submitted with a reconsideration request. You may also receive a timely filing denial when you do not submit a claim on time.

How to use:

Submit a reconsideration request electronically, phone, mail or fax with the following information:

- **Electronic claims:** Include the EDI acceptance report stating we received your claim.

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- **Mail or fax reconsiderations:** Submit a screen shot from your accounting software that shows the date you submitted the claim. The screen shot must show:
  - Correct member name.
  - Correct date of service.
  - Claim submission date.

Additional Information:

Timely filing limits can vary based on state requirements and contracts. If you do not know your timely filing limit, refer to your Provider Agreement.

Appeals (step two of dispute)

What is it?

An appeal is a second review of a reconsideration claim.

When to use:

If you do not agree with the outcome of the claim reconsideration decision in step one, use the claim appeal process.

How to use:

Submit related documents with your appeal. These may include a cover letter, medical records and additional information. Send your information electronically, by mail or fax. In your appeal, please include any supporting information not included with your reconsideration request.

- **Electronic claims:** Use the Claims Management or ClaimsLink application on Link. You may upload attachments.
- **Mail:** Send the appeal to:

  UnitedHealthcare Community Plan
  Grievances and Appeals
  P.O. Box 31364
  Salt Lake City, UT 84131-0364
- **Fax:** Send the appeal to **801-994-1082**.

We have a one-year timely filing limitation to complete all steps in the reconsideration and appeal process. It starts on the date of the first EOB.

TIPS FOR SUCCESSFUL CLAIMS RESOLUTION

To help process claim reconsiderations:

- Do not let claim issues grow or go unresolved.
- Call **Provider Services** if you can't verify a claim is on file.
- Do not resubmit validated claims on file unless submitting a corrected claim.
- File adjustment requests and claims disputes within contractual time requirements.
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity. If you have questions, call **Provider Services**.
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan.
- When submitting adjustment requests, provide the same information required for a clean claim. Explain the dispute, what should have been paid and why.
- Refer to your contract for submission deadlines concerning third-party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or the denial reason.

Overpayment

What is it?

An overpayment happens when we overpay a claim you don't dispute.

How to use:

If you or UnitedHealthcare Community Plan finds an overpaid claim, send us the overpayment within the time specified in your contract. If your payment is not received by that time, we may apply the overpayment against future claim payments in accordance with our Agreement and applicable law.

If you prefer we recoup the funds from your next payment, call Provider Services.

If you prefer to mail a refund, send an Overpayment Return Check or the Return Overpayment through the Adjustment Request form.

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Also send a letter with the check. Include the following:

- Name and contact information for the person authorized to sign checks or approve financial decisions.
- Member identification number.
- Date of service.
- Original claim number (if known).
- Date of payment.
- Amount paid.
- Amount of overpayment.
- Overpayment reason.
- Check number.

Where to send:

Mail refunds with an Overpayment Return Check or the Return Overpayment through Adjustment Request form to:

UnitedHealthcare Community Plan
ATTN: Recovery Services
P.O. Box 740804
Atlanta, GA 30374-0800

Instructions and forms are on **UHCprovider.com**.

If you do not agree with the overpayment findings, submit a dispute within the required timeframe as listed in your contract.

If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can appeal. See Dispute section in this chapter.

We make claim adjustments without requesting additional information from you. You will see the adjustment on the EOB or Provider Remittance Advice (PRA). When additional information is needed, we will ask you to provide it.

***The information provided is sample data only for illustrative purposes.**
Please populate and return with the data relevant to your claims that have been overpaid.

Member ID	Date of Service	Original Claim #	Date of Payment	Paid Amount	Amount of Overpayment	Reason for Overpayment
11111	01/01/14	14A000000001	01/31/14	115.03	115.03	Double payment of claim
2222222	02/02/14	14A000000002	03/15/14	279.34	27.19	Contract states $50, claim paid 77.29
3333333	03/03/14	14A000000003	04/01/14	131.41	99.81	You paid 4 units, we billed only 1
44444444	04/04/14	14A000000004	05/02/14	412.26	412.26	Member has other insurance
55555555	05/05/14	14A000000005	06/15/14	332.63	332.63	Member terminated

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Provider Grievance

What is it?

Grievances are complaints related to your UnitedHealthcare Community Plan policy, procedures or payments.

When to file:

You may file a grievance about:

- Benefits and limitations.
- Eligibility and enrollment of a member or care provider.
- Member issues or UnitedHealthcare Community Plan issues.
- Availability of health services from UnitedHealthcare Community Plan to a member.
- The delivery of health services.
- The quality of service.

How to file:

File verbally or in writing.

- **Phone:** Call Provider Services toll free at **800-600-9007**
- **Mail:** Send care provider name, contact information and your grievance to:

  UnitedHealthcare Community Plan
  Grievances and Appeals
  P.O. Box 31364
  Salt Lake City, UT 84131-0364

Member Grievances and Complaints Procedures

Pennsylvania Act 68 allows you, with written permission from the member, to act on their behalf to file a grievance. A form that the member can use to give consent is available in Appendix G. The form, or a document containing the same information the form provides, signed by the member, must be sent with the grievance. If you are taking responsibility to appeal on behalf of the member, you may not bill them for those denied services. Information on member complaints, grievances, and state fair hearings can be found in Apppendix F, the Complaint, Grievance, and Fair Hearing section of the UHC Community Plan for Families Member Handbook. You can also view the full member handbook at **UHCCommunityPlan.com**.

Fraud, Waste and Abuse

Call the toll-free **Fraud, Waste and Abuse Hotline** to report questionable incidents involving plan members or care providers.

UnitedHealthcare Community Plan's Anti-Fraud, Waste and Abuse Program focuses on prevention, detection and investigation of false and abusive acts committed by you and plan members. The program also helps identify, investigate and recover money UnitedHealthcare Community Plan paid for such claims. We also refer suspected fraud, waste and abuse cases to law enforcement, regulatory and administrative agencies according to state and federal law. UnitedHealthcare Community Plan seeks to protect the ethical and financial integrity of the company and its employees, members, care providers, government programs and the public. In addition, it aims to protect member health.

UnitedHealthcare Community Plan includes applicable federal and state regulatory requirements in its Anti-Fraud, Waste and Abuse Program. We recognize state and federal health plans are vulnerable to fraud, waste and abuse. As a result, we tailor our efforts to the unique needs of its members and Medicaid, Medicare and other government partners. This means we cooperate with law enforcement and regulatory agencies in the investigation or prevention of fraud, waste and abuse.

An important aspect of the Compliance Program is reviewing our operation's high- risk areas. Then we implement reviews and audits to help ensure compliance with law, regulations and contracts. You are contractually obligated to cooperate with the company and government authorities.

Find the PA DHS information on Fraud, Waste and Abuse at **dhs.pa.gov** or call **844-347-8477**.

The Deficit Reduction Act (DRA) has provisions reforming Medicare and Medicaid and reducing fraud within the federal health care programs. Every entity that receives at least $5 million in annual Medicaid payments must have written policies for entity employees and contractors. They

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must provide detailed information about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws. As a participating care provider with UnitedHealthcare Community Plan, you and your staff are subject to these provisions.

This policy details our commitment to compliance with the federal and state false claims acts. It provides a detailed description of these acts and of organizational mechanisms that detect and prevent fraud, waste and abuse. It also details how whistleblowing employees are protected. UnitedHealthcare Community Plan prohibits retaliation if a report is made in good faith.

EXCLUSION CHECKS

First-tier, downstream and related entities (FDRs), must review federal (HHS-OIG and GSA) and state exclusion lists before hiring/contracting employees (including temporary workers and volunteers), the CEO, senior administrators or managers, and sub-delegates. Employees and/or contractors may not be excluded from participating in federal health care programs. FDRs must review the federal and state exclusion lists every month. For more information or access to the publicly accessible, excluded party online databases, please see the following links:

- **Health and Human Services – Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE)**
- **General Services Administration (GSA) System for Award Management**

WHAT YOU NEED TO DO FOR EXCLUSION CHECKS

Review applicable exclusion lists and maintain a record of exclusion checks for 10 years. UnitedHealthcare Community Plan or CMS may ask for documentation to verify they were completed.

Pennsylvania Medical Assistance Hotline to Report Fraud and Abuse

DHS has a hotline to report suspected fraud and abuse committed by any entity providing services to Medical Assistance recipients.

The hotline number is **844-347-8477** and (844-DHS-TIPS). It is available 8:30 a.m. to 3:30 p.m., Monday through Friday. Voice mail is available at all other times. Callers may remain anonymous.

Suspected fraud and abuse may also be reported via the website at: **dhs.state.pa.us**.

The website contains additional information on reporting fraud and abuse.

Pennsylvania Medical Assistance Provider Self-Audit Protocol

The Pennsylvania Medical Assistance Provider Self Audit Protocol allows you to disclose overpayments or improper payments of MA funds. This is done through the **reporting fraud website**.

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Appendix F: Complaints, Grievances, and Fair Hearings

If a provider or UnitedHealthcare Community Plan does something that you are unhappy about or do not agree with, you can tell UnitedHealthcare Community Plan or the Department of Human Services what you are unhappy about or that you disagree with what the provider or UnitedHealthcare Community Plan has done. This section describes what you can do and what will happen.

Complaints

WHAT IS A COMPLAINT?

A Complaint is when you tell UnitedHealthcare Community Plan you are unhappy with UnitedHealthcare Community Plan or your provider or do not agree with a decision by UnitedHealthcare Community Plan.

Some things you may complain about:

- You are unhappy with the care you are getting.
- You cannot get the service or item you want because it is not a covered serviceor item.
- You have not gotten services that UnitedHealthcare Community Plan hasapproved.
- You were denied a request to disagree with a decision that you have to pay yourprovider.

First Level Complaint

WHAT SHOULD I DO IF I HAVE A COMPLAINT?

To file a first level Complaint:

- Call UnitedHealthcare Community Plan at 1-800-414-9025, TTY/PA RELAY 711and tell UnitedHealthcare Community Plan your Complaint, or
- Write down your Complaint and send it to UnitedHealthcare Community Plan bymail or fax, or
- If you received a notice from UnitedHealthcare Community Plan telling you UnitedHealthcare Community Plan's decision and the notice included a Complaint/Grievance Request Form, fill out the form and send it to UnitedHealthcare Community Plan by mail or fax.

UnitedHealthcare Community Plan's address and fax number for Complaints:

UnitedHealthcare Community Plan of Pennsylvania
P.O. Box 31364
Salt Lake City, UT 84131-0364
877-886-8120

Your provider can file a Complaint for you if you give the provider your consent in writing to do so.

WHEN SHOULD I FILE A FIRST LEVEL COMPLAINT?

Some Complaints have a time limit on filing. You must file a Complaint within **60 days of getting a notice** telling you that:

- UnitedHealthcare Community Plan has decided that you cannot get a service oritem you want because it is not a covered service or item.
- UnitedHealthcare Community Plan will not pay a provider for a service or itemyou got.
- UnitedHealthcare Community Plan did not tell you its decision about a Complaintor Grievance you told UnitedHealthcare Community Plan about within 30 daysfrom when UnitedHealthcare Community Plan got your Complaint or Grievance.
- UnitedHealthcare Community Plan has denied your request to disagree with UnitedHealthcare Community Plan's decision that you have to pay your provider.

You must file a Complaint within **60 days of the date you should have gotten a service or item** if you did not get a service or item. The time by which you should have received a service or item is listed below:

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New member appointment for your first examination...	We will make an appointment for you...
members with HIV/AIDS	with PCP or specialist no later than 7 days after you become a member in UnitedHealthcare Community Plan unless you are already being treated by a PCP or specialist.
members who receive Supplemental Security Income (SSI)	with PCP or specialist no later than 45 days after you become a member in UnitedHealthcare Community Plan, unless you are already being treated by a PCP or specialist.
members under the age of 21	with PCP for an EPSDT exam no later than 45 days after you become a member in UnitedHealthcare Community Plan, unless you are already being treated by a PCP or specialist.
all other members	with PCP no later than 3 weeks after you become a member in UnitedHealthcare Community Plan.
Members who are pregnant:	**We will make an appointment for you...**
pregnant women in their first trimester	with OB/GYN provider within 10 business days of UnitedHealthcare Community Plan learning you are pregnant.
pregnant women in their second trimester	with OB/GYN provider within 5 business days of UnitedHealthcare Community Plan learning you are pregnant.
pregnant women in their third trimester	with OB/GYN provider within 4 business days of UnitedHealthcare Community Plan learning you are pregnant.
pregnant women with high-risk pregnancies	with OB/GYN provider within 24 hours of UnitedHealthcare Community Plan learning you are pregnant.
Appointment with...	**An appointment must be scheduled...**
urgent medical condition	within 24 hours.
routine appointment	within 10 business days.
health assessment/general physical examination	within 3 weeks.
Specialists (when referred by PCP)	
urgent medical condition	within 24 hours of referral.

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routine appointment with one of the following specialists: • Otolaryngology • Dermatology • Pediatric Endocrinology • Pediatric General Surgery • Pediatric Infectious Disease • Pediatric Neurology • Pediatric Pulmonology • Pediatric Rheumatology • Dentist • Orthopedic Surgery • Pediatric Allergy & Immunology • Pediatric Gastroenterology • Pediatric Hematology • Pediatric Nephrology • Pediatric Oncology • Pediatric Rehab Medicine • Pediatric Urology • Pediatric Dentistry	within 15 business days of referral
routine appointment with all other specialists	within 10 business days of referral

You may file **all other Complaints at any time**.

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WHAT HAPPENS AFTER I FILE A FIRST LEVEL COMPLAINT?

After you file your Complaint, you will get a letter from UnitedHealthcare Community Plan telling you that UnitedHealthcare Community Plan has received your Complaint, and about the First Level Complaint review process.

You may ask UnitedHealthcare Community Plan to see any information UnitedHealthcare Community Plan has about the issue you filed your Complaint about at no cost to you. You may also send information that you have about your Complaint to UnitedHealthcare Community Plan.

You may attend the Complaint review if you want to attend it. UnitedHealthcare Community Plan will tell you the location, date, and time of the Complaint review at least 7 days before the day of the Complaint review. You may appear at the Complaint review in person, by phone, or by videoconference, if available. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee of one or more UnitedHealthcare Community Plan staff who were not involved in and do not work for someone who was involved in the issue you filed your Complaint about will meet to make a decision about your Complaint. If the Complaint is about a clinical issue, a licensed doctor will be on the committee. UnitedHealthcare Community Plan will mail you a notice within 30 days from the date you filed your First Level Complaint to tell you the decision on your First Level Complaint. The notice will also tell you what you can do if you do not like the decision.

If you need more information about help during the Complaint process, see **page 122**.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and you file a Complaint verbally, or that is faxed, postmarked, or hand-delivered within 10 days of the date on the notice telling you that the services or items you have been receiving are not covered services or items for you, the services or items will continue until a decision is made.

WHAT IF I DO NOT LIKE UNITEDHEALTHCARE COMMUNITY PLAN'S DECISION?

You may ask for an external Complaint review, a Fair Hearing, or an external Complaint review and a Fair Hearing if the Complaint is about one of the following:

- UnitedHealthcare Community Plan's decision that you cannot get a service oritem you want because it is not a covered service or item.
- UnitedHealthcare Community Plan's decision to not pay a provider for a serviceor item you got.
- UnitedHealthcare Community Plan's failure to decide a Complaint or Grievanceyou told UnitedHealthcare Community Plan about within 30 days from whenUnitedHealthcare Community Plan got your Complaint or Grievance.
- You not getting a service or item within the time by which you should havereceived it
- UnitedHealthcare Community Plan's decision to deny your request to disagreewith UnitedHealthcare Community Plan's decision that you have to pay yourprovider.

You must ask for an external Complaint review within **15 days of the date you got the First Level Complaint decision notice**.

You must ask for a Fair Hearing within **120 days from the date on the notice** telling you the Complaint decision.

For all other Complaints, you may file a Second Level Complaint within **45 days of the date you got the Complaint decision notice**.

For information about Fair Hearings, see **page 123**.

For information about external Complaint review, see **page 115**.

If you need more information about help during the Complaint process, see **page 122**.

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Second Level Complaint

WHAT SHOULD I DO IF I WANT TO FILE A SECOND LEVEL COMPLAINT?

To file a Second Level Complaint:

- Call UnitedHealthcare Community Plan at 1-800-414-9025, TTY/PA RELAY 711and tell UnitedHealthcare Community Plan your Second Level Complaint, or
- Write down your Second Level Complaint and send it to UnitedHealthcareCommunity Plan by mail or fax, or
- Fill out the Complaint Request Form included in your Complaint decision noticeand send it to UnitedHealthcare Community Plan by mail or fax.

UnitedHealthcare Community Plan's address and fax number for Second Level Complaints

UnitedHealthcare Community Plan of Pennsylvania
P.O. Box 31364
Salt Lake City, UT 84131-0364
877-886-8120

WHAT HAPPENS AFTER I FILE A SECOND LEVEL COMPLAINT?

After you file your Second Level Complaint, you will get a letter from UnitedHealthcare Community Plan telling you that UnitedHealthcare Community Plan has received your Complaint, and about the Second Level Complaint review process.

You may ask UnitedHealthcare Community Plan to see any information UnitedHealthcare Community Plan has about the issue you filed your Complaint about at no cost to you. You may also send information that you have about your Complaint to UnitedHealthcare Community Plan.

You may attend the Complaint review if you want to attend it. UnitedHealthcare Community Plan will tell you the location, date, and time of the Complaint review at least 15 days before the Complaint review. You may appear at the Complaint review in person, by phone, or by videoconference, if available. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee of 3 or more people, including at least 1 person who does not work for UnitedHealthcare Community Plan, will meet to decide your Second Level Complaint. The UnitedHealthcare Community Plan staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Complaint about. If the Complaint is about a clinical issue, a licensed doctor will be on the committee. UnitedHealthcare Community Plan will mail you a notice within 45 days from the date your Second Level Complaint was recieved to tell you the decision on your Second Level Complaint. The letter will also tell you what you can do if you do not like the decision.

If you need more information about help during the Complaint process, see **page 122**.

WHAT IF I DO NOT LIKE UNITEDHEALTHCARE COMMUNITY PLAN'S DECISION ON MY SECOND LEVEL COMPLAINT?

You may ask for an external review by either the Department of Health or the Insurance Department.

You must ask for an external review **within 15 days of the date you got the Second Level Complaint decision notice**.

External Complaint Review

HOW DO I ASK FOR AN EXTERNAL COMPLAINT REVIEW?

You must send your request for external review of your Complaint in writing to either:

Pennsylvania Department of Health
Bureau of Managed Care
Health and Welfare Building, Room 912
625 Forster Street
Harrisburg, Pennsylvania 17120-0701

Telephone Number: 888-466-2787

OR

Pennsylvania Insurance Department
Bureau of Consumer Services
Room 1209, Strawberry Square
Harrisburg, PA 17120

Telephone Number: 877-881-6388

If you ask, the Department of Health will help you put your Complaint in writing.

The Department of Health handles Complaints that involve the way a provider gives care or services. The

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Insurance Department reviews Complaints that involve UnitedHealthcare Community Plan's policies and procedures. If you send your request for external review to the wrong Department, it will be sent to the correct Department.

WHAT HAPPENS AFTER I ASK FOR AN EXTERNAL COMPLAINT REVIEW?

The Department of Health or the Insurance Department will get your file from UnitedHealthcare Community Plan. You may also send them any other information that may help with the external review of your Complaint.

You may be represented by an attorney or another person such as your representative during the external review.

A decision letter will be sent to you after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you do not like the decision.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and your request for an external Complaint review is postmarked or hand-delivered within 10 days of the date on the notice telling you UnitedHealthcare Community Plan's First Level Complaint decision that you cannot get services or items you have been receiving because they are not covered services or items for you, the services or items will continue until a decision is made.

Grievances

WHAT IS A GRIEVANCE?

When UnitedHealthcare Community Plan denies, decreases, or approves a service or item different than the service or item you requested because it is not medically necessary, you will get a notice telling you UnitedHealthcare Community Plan's decision.

A Grievance is when you tell UnitedHealthcare Community Plan you disagree with UnitedHealthcare Community Plan's decision.

WHAT SHOULD I DO IF I HAVE A GRIEVANCE?

To file a Grievance:

- Call UnitedHealthcare Community Plan at 1-800-414-9025, TTY/PA RELAY 711 and tell UnitedHealthcare Community Plan your Grievance, or
- Write down your Grievance and send it to UnitedHealthcare Community Plan by mail or fax, or
- Fill out the Complaint/Grievance Request Form included in the denial notice you got from UnitedHealthcare Community Plan and send it to UnitedHealthcare Community Plan by mail or fax.

UnitedHealthcare Community Plan's address and fax number for Grievances:

> **UnitedHealthcare Community Plan of Pennsylvania**
> P.O. Box 31364
> Salt Lake City, UT 84131-0364
> 877-886-8120

Your provider can file a Grievance for you if you give the provider your consent in writing to do so. If your provider files a Grievance for you, you cannot file a separate Grievance on your own.

WHEN SHOULD I FILE A GRIEVANCE?

You must file a Grievance within **60 days from the date you get the notice** telling you about the denial, decrease, or approval of a different service or item for you.

WHAT HAPPENS AFTER I FILE A GRIEVANCE?

After you file your Grievance, you will get a letter from UnitedHealthcare Community Plan telling you that UnitedHealthcare Community Plan has received your Grievance, and about the Grievance review process.

You may ask UnitedHealthcare Community Plan to see any information that UnitedHealthcare Community Plan used to make the decision you filed your Grievance about at no cost to you. You may also send information that you have about your Grievance to UnitedHealthcare Community Plan.

You may attend the Grievance review if you want to attend it. UnitedHealthcare Community Plan will tell you the location, date, and time of the Grievance review at least 15 days before the day of the Grievance review. You may appear at the Grievance review in person, by phone, or by videoconference, if available. If you decide that you do not want to attend the Grievance review, it will not affect the decision.

A committee of 3 or more people, including a licensed doctor, will meet to decide your Grievance. The UnitedHealthcare Community Plan staff on the committee

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will not have been involved in and will not have worked for someone who was involved in the issue you filed your Grievance about. UnitedHealthcare Community Plan will mail you a notice 30 days from the date your Grievance was recieved to tell you the decision on HealthChoices 2018 Model Member Handbook your Grievance. The notice will also tell you what you can do if you do not like the decision.

If you need more information about help during the Grievance process, see **page 122**.

What to do to continue getting services:

If you have been getting services or items that are being reduced, changed, or denied and you file a Grievance verbally, or that is faxed, postmarked, or hand-delivered within 10 days of the date on the notice telling you that the services or items you have been receiving are being reduced, changed, or denied, the services or items will continue until a decision is made.

WHAT IF I DO NOT LIKE UNITEDHEALTHCARE COMMUNITY PLAN'S DECISION?

You may ask for an external Grievance review or a Fair Hearing or you may ask for both an external Grievance review and a Fair Hearing. An external Grievance review is a review by a doctor who does not work for UnitedHealthcare Community Plan.

You must ask for an external Grievance review within **15 days of the date you got the Grievance decision notice**.

You must ask for a Fair Hearing from the Department of Human Services **within 120 days from the date on the notice** telling you the Grievance decision.

For information about Fair Hearings, see **page 123**.

For information about external Grievance review, see below.

If you need more information about help during the Grievance process, see **page 122**.

External Grievance Review

HOW DO I ASK FOR EXTERNAL GRIEVANCE REVIEW?

To ask for an external Grievance review:

- Call UnitedHealthcare Community Plan at 800-414-9025, TTY/PA RELAY 711 and tell UnitedHealthcare Community Plan your Grievance, or
- Write down your Grievance and send it to UnitedHealthcare Community Plan by mail to:

UnitedHealthcare Community Plan of Pennsylvania
P.O. Box 31364
Salt Lake City, UT 84131-0364

UnitedHealthcare Community Plan will send your request for external Grievance review to the Department of Health.

WHAT HAPPENS AFTER I ASK FOR AN EXTERNAL GRIEVANCE REVIEW?

The Department of Health will notify you of the external Grievance reviewer's name, address and phone number. You will also be given information about the external Grievance review process.

UnitedHealthcare Community Plan will send your Grievance file to the reviewer. You may provide additional information that may help with the external review of your Grievance to the reviewer within 15 days of filing the request for an external Grievance review.

You will receive a decision letter within 60 days of the date you asked for an external Grievance review. This letter will tell you all the reason(s) for the decision and what you can do if you do not like the decision.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed, or denied and you ask for an external Grievance review verbally or in a letter that is postmarked or hand-delivered within 10 days of the date on the notice telling you UnitedHealthcare Community Plan's Grievance decision, the services or items will continue until a decision is made.

Expedited Complaints and Grievances

WHAT CAN I DO IF MY HEALTH IS AT IMMEDIATE RISK?

If your doctor or dentist believes that waiting 30 days to get a decision about your Complaint or Grievance could

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harm your health, you or your doctor or dentist may ask that your Complaint or Grievance be decided more quickly. For your Complaint or Grievance to be decided more quickly:

- You must ask UnitedHealthcare Community Plan for an early decision by calling UnitedHealthcare Community Plan at 800-414-9025, TTY/PA RELAY 711, faxing a letter or the Complaint/Grievance Request Form to 801-994-1261, or sending an email to **pa_csa_ga_intake@uhc.com**
- Your doctor or dentist should fax a signed letter to 801-994-1261 within 72 hours of your request for an early decision that explains why UnitedHealthcare Community Plan taking 30 days to tell you the decision about your Complaint or Grievance could harm your health.

If UnitedHealthcare Community Plan does not receive a letter from your doctor or dentist and the information provided does not show that taking the usual amount of time to decide your Complaint or Grievance could harm your health, UnitedHealthcare Community Plan will decide your Complaint or Grievance in the usual time frame of 30 days from when UnitedHealthcare Community Plan first got your Complaint or Grievance.

Expedited Complaint and Expedited External Complaint

Your expedited Complaint will be reviewed by a committee that includes a licensed doctor. Members of the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Complaint about.

You may attend the expedited Complaint review if you want to attend it. You can attend the Complaint review in person, but may have to appear by phone or by videoconference because UnitedHealthcare Community Plan has a short amount of time to decide an expedited Complaint. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

UnitedHealthcare Community Plan will tell you the decision about your Complaint within 48 hours of when UnitedHealthcare Community Plan gets your doctor's or dentist's letter explaining why the usual time frame for deciding your Complaint will harm your health or within 72 hours from when UnitedHealthcare Community Plan gets your request for an early decision, whichever is sooner, unless you ask UnitedHealthcare Community Plan to take more time to decide your Complaint. You can ask UnitedHealthcare Community Plan to take up to 14 more days to decide your Complaint. You will also get a notice telling you the reason(s) for the decision and how to ask for expedited external Complaint review, if you do not like the decision.

If you did not like the expedited Complaint decision, you may ask for an expedited external Complaint review from the Department of Health within 2 business days from the date you get the expedited Complaint decision notice. To ask for expedited external review of a Complaint:

- Call UnitedHealthcare Community Plan at 800-414-9025, TTY/PA RELAY 711 and tell UnitedHealthcare Community Plan your Complaint, or
- Send an email to UnitedHealthcare Community Plan at **pa_csa_ga_intake@uhc.com**, or
- Write down your Complaint and send it to UnitedHealthcare Community Plan by mail or fax:

UnitedHealthcare Community Plan of Pennsylvania
P.O. Box 31364
Salt Lake City, UT 84131-0364
801-994-1261

Expedited Grievance and Expedited External Grievance

A committee of three or more people, including a licensed doctor, will meet to decide your Grievance. The UnitedHealthcare Community Plan staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Grievance about.

You may attend the expedited Grievance review if you want to attend it. You can attend the Grievance review in person, but may have to appear by phone or by videoconference because UnitedHealthcare Community Plan has a short amount of time to decide the expedited Grievance. If you decide that you do not want to attend the Grievance review, it will not affect our decision.

UnitedHealthcare Community Plan will tell you the

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decision about your Grievance within 48 hours of when UnitedHealthcare Community Plan gets your doctor's or dentist's letter explaining why the usual time frame for deciding your Grievance will harm your health or within 72 hours from when UnitedHealthcare Community Plan gets your request for an early decision, whichever is sooner, unless you ask UnitedHealthcare Community Plan to take more time to decide your Grievance. You can ask UnitedHealthcare Community Plan to take up to 14 more days to decide your Grievance. You will also get a notice telling you the reason(s) for the decision and what to do if you do not like the decision.

If you do not like the expedited Grievance decision, you may ask for an expedited external Grievance review or an expedited Fair Hearing by the Department of Human Services or both an expedited external Grievance review and an expedited Fair Hearing.

You must ask for expedited external Grievance review by the Department of Health within **two business days from the date you get the expedited Grievance decision notice**. To ask for expedited external review of a Grievance:

- Call UnitedHealthcare Community Plan at 800-414-9025, TTY/PA RELAY 711 and tell UnitedHealthcare Community Plan your Grievance, or
- Send an email to UnitedHealthcare Community Plan at pa_csa_ga_intake@uhc.com, or
- Write down your Grievance and send it to UnitedHealthcare Community Plan by mail or fax:

  UnitedHealthcare Community Plan of Pennsylvania
  P.O. Box 31364
  Salt Lake City, UT 84131-0364
  801-994-1261

UnitedHealthcare Community Plan will send your request to the Department of Health within 24 hours after receiving it.

You must ask for a Fair Hearing within **120 days from the date on the notice** telling you the expedited Grievance decision.

WHAT KIND OF HELP CAN I HAVE WITH THE COMPLAINT AND GRIEVANCE PROCESSES?

If you need help filing your Complaint or Grievance, a staff member of UnitedHealthcare Community Plan will help you. This person can also represent you during the Complaint or Grievance process. You do not have to pay for the help of a staff member. This staff member will not have been involved in any decision about your Complaint or Grievance.

You may also have a family member, friend, lawyer or other person help you file your Complaint or Grievance. This person can also help you if you decide you want to appear at the Complaint or Grievance review.

At any time during the Complaint or Grievance process, you can have someone you know represent you or act for you. If you decide to have someone represent or act for you, tell UnitedHealthcare Community Plan, in writing, the name of that person and how UnitedHealthcare Community Plan can reach him or her.

You or the person you choose to represent you may ask UnitedHealthcare Community Plan to see any information UnitedHealthcare Community Plan has about the issue you filed your Complaint or Grievance about at no cost to you.

You may call UnitedHealthcare Community Plan's toll-free telephone number at 1-800-414-9025, TTY/PA RELAY 711 if you need help or have questions about Complaints and Grievances, you can contact your local legal aid office at 1-800-322-7572 or call the Pennsylvania Health Law Project at 1-800-274-3258.

Persons Whose Primary Language Is Not English

If you ask for language services, UnitedHealthcare Community Plan will provide the services at no cost to you.

Persons with Disabilities

UnitedHealthcare Community Plan will provide persons with disabilities with the following help in presenting Complaints or Grievances at no cost, if needed. This help includes:

- Providing sign language interpreters;
- Providing information submitted by UnitedHealthcare Community Plan at the Complaint or Grievance review in an alternative format. The alternative format version will be given to you before the review; and

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- Providing someone to help copy and present information.

Department of Human Services Fair Hearings

In some cases you can ask the Department of Human Services to hold a hearing because you are unhappy about or do not agree with something UnitedHealthcare Community Plan did or did not do. These hearings are called "Fair Hearings." You can ask for a Fair Hearing after UnitedHealthcare Community Plan decides your First Level Complaint or decides your Grievance.

WHAT CAN I REQUEST A FAIR HEARING ABOUT AND BY WHEN DO I HAVE TO ASK FOR A FAIR HEARING?

Your request for a Fair Hearing must be postmarked within **120 days from the date on the notice** telling you UnitedHealthcare Community Plan's decision on your First Level Complaint or Grievance about the following:

- The denial of a service or item you want because it is not a covered service or item.
- The denial of payment to a provider for a service or item you got and the provider can bill you for the service or item.
- UnitedHealthcare Community Plan's failure to decide a First Level Complaint or Grievance you told UnitedHealthcare Community Plan about within 30 days from when UnitedHealthcare Community Plan got your Complaint or Grievance.
- The denial of your request to disagree with UnitedHealthcare Community Plan's decision that you have to pay your provider.
- The denial of a service or item, decrease of a service or item, or approval of a service or item different from the service or item you requested because it was not medically necessary.
- HealthChoices 2018 Model Member Handbook
- You're not getting a service or item within the time by which you should have received a service or item.

You can also request a Fair Hearing within 120 days from the date on the notice telling you that UnitedHealthcare Community Plan failed to decide a First Level Complaint or Grievance you told UnitedHealthcare Community Plan about within 30 days from when UnitedHealthcare Community Plan got your Complaint or Grievance.

HOW DO I ASK FOR A FAIR HEARING?

Your request for a Fair Hearing must be in writing. You can either fill out and sign the Fair Hearing Request Form included in the Complaint or the Grievance decision notice or write a letter.

If you write a letter, it needs to include the following information:

- Your (the member's) name and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have the Fair Hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing; and
- A copy of any letter you received about the issue you are asking for a Fair Hearing about.

You must send your request for a Fair Hearing to the following address:

Department of Human Services
Office of Medical Assistance Programs –
HealthChoices Program Complaint, Grievance and Fair hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

WHAT HAPPENS AFTER I ASK FOR A FAIR HEARING?

You will get a letter from the Department of Human Services' Bureau of Hearings and Appeals telling you where the hearing will be held and the date and time for the hearing. You will receive this letter at least 10 days before the date of the hearing.

You may come to where the Fair Hearing will be held or be included by phone. A family member, friend, lawyer or other person may help you during the Fair Hearing. You **MUST** participate in the Fair Hearing.

UnitedHealthcare Community Plan will also go to your Fair Hearing to explain why UnitedHealthcare Community Plan

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made the decision or explain what happened.

You may ask UnitedHealthcare Community Plan to give you any records, reports and other information about the issue you requested your Fair Hearing about at no cost to you.

WHEN WILL THE FAIR HEARING BE DECIDED?

The Fair Hearing will be decided within 90 days from when you filed your Complaint or Grievance with UnitedHealthcare Community Plan, not including the number of days between the date on the written notice of the UnitedHealthcare Community Plan's First Level Complaint decision or Grievance decision and the date you asked for a Fair Hearing.

If you requested a Fair Hearing because UnitedHealthcare Community Plan did not tell you its decision about a Complaint or Grievance you told UnitedHealthcare Community Plan about within 30 days from when UnitedHealthcare Community Plan got your Complaint or Grievance, your Fair Hearing will be decided within 90 days from when you filed your Complaint or Grievance with UnitedHealthcare Community Plan, not including the number of days between the date on the notice telling you that UnitedHealthcare Community Plan failed to timely decide your Complaint or Grievance and the date you asked for a Fair Hearing.

The Department of Human Services will send you the decision in writing and tell you what to do if you do not like the decision.

If your Fair Hearing is not decided within 90 days from the date the Department of Human Services receives your request, you may be able to get your services until your Fair Hearing is decided. You can call the Department of Human Services at 1-800-798-2339 to ask for your services.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and you ask for a Fair Hearing and your request is postmarked or hand-delivered within 10 days of the date on the notice telling you UnitedHealthcare Community Plan's First Level Complaint or Grievance decision, the services or items will continue until a decision is made.

Expedited Fair Hearing

WHAT CAN I DO IF MY HEALTH IS AT IMMEDIATE RISK?

If your doctor or dentist believes that waiting the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. This is called an expedited Fair Hearing. You can ask for an early decision by calling the Department at 1-800-798-2339 or by faxing a letter or the Fair Hearing Request Form to 717-772-6328. Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor ordentist must testify at the Fair Hearing to explain why taking the usual amount of time todecide your Fair Hearing could harm your health.

The Bureau of Hearings and Appeals will schedule a telephone hearing and will tell you its decision within 3 business days after you asked for a Fair Hearing.

If your doctor does not send a written statement and does not testify at the Fair Hearing, the Fair Hearing decision will not be expedited. Another hearing will be scheduled and the Fair Hearing will be decided using the usual time frame for deciding a Fair Hearing.

You may call UnitedHealthcare Community Plan's toll-free telephone number at **800-414-9025**, TTY/PA RELAY 711 if you need help or have questions about Fair Hearings, you can contact your local legal aid office at **800-322-7572** or call the Pennsylvania Health Law Project at **800-274-3258**.

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Appendix G: Consent for Provider to File a Grievance for Member

Provider Name	Provider Plan ID Number
Provider Address	
Description of Specific Service or Item for which I agree the Provider Can File a Grievance	
Name and Address of PH-MCO Where Grievance Will Be Filed	

Name of Member	Member's Date of Birth
Member ID No.	
Member Mailing Address	
Member Daytime Telephone Number	Member Evening Telephone Number

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I, **[Name of Member]**, agree that **[Name of Provider]** can file a Grievance for me with **[PH-MCO]** about the service or item described above.

By signing this consent form, I understand the following:

1. I or my representative may not file a Grievance about the service or item listed in this consent form unless I or my representative takes back my consent in writing. I have the right to take back my consent at any time during the Grievance process by telling **[PH-MCO Name]** and **[Name of Provider]** in writing that I do not want **[Name of Provider]** to continue the Grievance process for me.
2. My consent to have the Provider file the Grievance for me will automatically no longer be in effect if the Provider does not file a Grievance or does not continue with the Grievance through the end of the Grievance review process.
3. I or my representative has read, or has been read, this consent form, and have had it explained to me until I understand it. I or my representative understands the information in this consent form.

____

Signature of Member or Representative   Date

____

Witness Signature   Date

____

Print Witness Name

If the Member is unable to sign this Consent Form because the Member is legally incompetent:

____

Name of Person Signing on Behalf of Member

____

Address of Person Signing on Behalf of Member

____

Relationship of Person Signing to Member

GG20 HealthChoices Standard Consent for Provider to File Grievance on Behalf of Member Template – January 1, 2018

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