## UnitedHealthcare Community Plan of Louisiana

# Claim Dispute, Reconsideration and Appeal

## Quick Reference Guide

**Use this reference guide to help you understand your options when you disagree with a prior authorization adverse determination or a claim denial.**

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. You can find more information about claim reconsiderations, appeals and grievances in the Care Provider Manual at UHCprovider.com/LAcommunityplan > Provider Administrative Manual and Guides.

Here's an overview of the types of disputes and processes that may apply when you receive an adverse determination from UnitedHealthcare Community Plan.

## Notice of Adverse Determination

Adverse determination decisions may include UnitedHealthcare Community Plan's decision to deny a service authorization request or to authorize a service in an amount, duration, or scope less than requested. We send a Notice of Adverse Determination to the care provider and the member. This notice includes instructions on how to request a **peer-to-peer (P2P) review** or submit a **member appeal**.

A **member appeal** can be submitted by the member, an authorized representative of the member or a care provider on behalf of a member, with the member's written consent. Submit a member appeal within 60 calendar days from the date on the Notice of Adverse Determination.

**Once the claim is submitted and partially paid or denied, the care provider may follow the Claims Dispute Resolution process.**

## Claim Dispute Resolution

Submit a claim reconsideration when you think a claim has not been properly processed. You must submit your request within 180 days from the date of the explanation of benefits (EOB) or provider remittance advice (PRA).

You can download the Claim and Clinical Reconsideration Request Forms at UHCprovider.com/LAcommunityplan > Claims and Payments > Claim Reconsideration. You can also submit and track your request using the claimsLink tool at UHCprovider.com/claimsLink.

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A **Claim Reconsideration** or **Clinical/Medical Claim Reconsideration** is a request for review of a claim that you believe was incorrectly paid or denied because of processing errors or missing documentation. This is typically the quickest way to address any concerns about the processing of your claim. We review whether a claim was paid correctly and also confirm that your provider information and/or contract are set up correctly in our system.

**Care Provider Appeal**
An appeal is a second review of a reconsideration claim. Send appeals 60 calendar days from the first-level reconsideration decision date or the PRA.

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.

## Independent Review Requests

Through the 2017 Regular Session Act No. 349, House Bill No. 492, effective Jan. 1, 2018, the Louisiana Department of Health (LDH) developed and implemented a process to allow health care providers the right to request an independent review of claims submitted to Medicaid-managed care organizations. This process helps to provide care providers with a review of potentially adverse claim payment determinations.

You can request an independent review within 180 calendar days from the date of the initial claim denial notice. Before requesting an independent review, you must first request a claim reconsideration with UnitedHealthcare Community Plan by completing the Independent Review Provider Reconsideration Form at UHCprovider.com/LAcommunityplan > Claims and Payments > Claim Reconsideration.

Complete the form within 180 days from the adverse determination and email the form to cs_la_ag_iro@uhc.com. We'll acknowledge the receipt of the form in writing within five calendar days. UnitedHealthcare Community Plan will make a final decision and provide a response within 45 calendar days from the date of receiving the request for reconsideration.

**LDH Independent Review**
You can find more about the LDH independent review process, how to request an independent review, and copies of the LDH Independent Review Request Form on LDH's website. The Independent Review Committee will give you the appropriate submission address. Along with a completed Independent Review Request Form, include a copy of the UnitedHealthcare Independent Review Provider Reconsideration Form and decision letter.

## Link and UHCprovider.com

Link self-service tools can quickly provide the comprehensive information you may need for most UnitedHealthcare benefit plans – without the extra step of calling for information. Use Link to perform secure online transactions such as checking member eligibility and benefits, managing claims and requesting prior authorization. You can capture screenshots of your activity or record reference numbers for better documentation.

To sign in to Link, go to UHCprovider.com and click on the Link button in the top right corner. If you aren't registered yet, go to **UHCprovider.com** and select "New User" to begin registration. To learn more about using Link, please visit UHCprovider.com/link.

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