UnitedHealthcare® Oxford

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Administrative Policy

MEMBER ADMINISTRATIVE GRIEVANCE & APPEAL (NON UM) PROCESS & TIMEFRAMES

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Related Policies

- Disclosure Policy
- Practitioner/Provider Administrative Claim Reconsideration and Appeal Process

INSTRUCTIONS FOR USE

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

APPLICABLE LINES OF BUSINESS/PRODUCTS

This policy applies to Oxford Commercial plan membership.

Note: Self-funded plans may be excluded from participation in some levels of the appeal process. Consult with individual group administrators for specific appeals process.

PURPOSE

The purpose of this policy is to outline the process and timeframes of an administrative grievance/appeal.

DEFINITIONS

Term	Applicable State	Definition
Administrative Grievance/Appeal	**CT, NJ, & NY**	Is a request to reverse an administrative (non-clinical, non-utilization management) determination such as payment of claims, coverage of services, disenrollment or missing referrals.
Administrative Issues	**NJ**	Any other plan requirement that does not fall into the benefit issue category (see below) including access to providers.
Adverse Benefit Determination	**NJ**	A denial, reduction or termination of, or a failure to make payment (in whole or in part) for, a benefit, including a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because Oxford determines the item or service to be

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Term	Applicable State	Definition
Adverse Benefit Determination *(continued)*	**NJ**	experimental or investigational, cosmetic, dental rather than medical, excluded as a pre-existing condition or because the HMO has rescinded the coverage.
Adverse Determination	**CT & NY**	A denial, reduction, termination, or failure to make payment (in whole or in part) of a benefit.
Benefit Issue	**NJ**	Include, but are not limited to, denials based on benefit exclusions or limitations and payment disputes.
Claim	**CT & NY**	Any request for service or a request for payment including pre-service, concurrent, or post-service benefits.
	NJ	A request by a member, a participating health care provider or a nonparticipating health care provider who has received an assignment of benefits from the member, for payment relating to health care services or supplies covered under a health benefits plan issued by Oxford.
Claimant	**CT, NJ, & NY**	The covered member or the member's authorized designee.
Concurrent Care Decision (Continued, Extended or Additional Services)	**CT, NJ, & NY**	Decisions affecting the ongoing course of treatment over a certain period of time or a number of treatments.
Expedited Review	**CT, NJ, & NY**	Is a modified review process for a claim involving urgent or emergent care
Final Internal Adverse Benefit Determination	**NJ**	An adverse benefit determination that has been upheld by Oxford at the completion of the internal appeal process, an adverse benefit determination with respect to which Oxford has waived its right to an internal review of the appeal, an adverse benefit determination for which Oxford did not comply with the requirements of N.J.A.C. 11:24-8.4 or 8.5, and an adverse benefit determination for which the member or provider has applied for expedited external review at the same time as applying for an expedited internal appeal.
Practitioner	**CT, NJ, & NY**	An individual who provides professional health care services, i.e., physicians, nurse practitioners and specialists.
Pre-certification (Pre-Service Claim)	**CT & NY**	A request for services (Prospective), which requires approval by Oxford, in whole or in part, before the service can be rendered: a service that must be approved in advance before it is rendered.
	NJ	Any claim for a benefit with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.
Pre-certification, Urgent	**CT, NJ, & NY**	Requires immediate action, although it may not be a life-threatening circumstance. An urgent situation could seriously jeopardize the life or health of the covered member or the ability of the member to regain maximum function or in the opinion of a physician with knowledge of the claimant's condition would subject the member to severe pain that cannot be adequately managed without the health care service or treatment being requested. An urgent care condition is a situation that has the potential to become an emergency in the absence of treatment. When determining whether a benefit request shall be considered an urgent care request, an individual acting on behalf of a health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine, except that any benefit request determined to be an urgent care request by a health care professional with knowledge of the covered person's medical condition shall be deemed an urgent care request.
Provider	**CT, NJ, & NY**	An institution or organization that provides services to Members, i.e., hospitals, skilled nursing facilities and home care agencies.
Retrospective (Post-Service)	**CT & NY**	Assessing appropriateness of medical services on a case-by-case or aggregate basis after services have been provided such as a claim for services that have already been rendered.
	NJ	Any claim for a benefit that is not a “pre-service claim.”

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POLICY

This policy represents regulatory standards as well as contractual agreements with Oxford Members, Providers and other health care professionals. Oxford follows these guidelines to comply with the claimant's right to appeal administrative determinations.

PROCEDURES AND RESPONSIBILITIES

Overview

Who can submit a grievance or an appeal:
A claimant can initiate an appeal. Claimants include:
- Member
- Member's designee with appropriate signed consent (attorney, relative, other interested party.)
- Provider/Practitioner on behalf of the Member, with appropriate signed consent from the Member.

Initiating grievance or appeal

Appeal Method	Contact Information
Verbally	Member Service Associates: 1-800-444-6222
Written Appeals	Correspondence Department P.O. Box 29134 Hot Springs, AR 71903
Electronic (Connecticut Plans Only)	Fax: 203-601-6893

CT Products

In reference to Members undergoing treatment pending the outcome of an appeal or grievance, the following guidelines apply to members enrolled on CT products:
- **Non-urgent concurrent review request**: Effective October 1, 2013, if an adverse determination or final adverse determination has been made on a non-urgent concurrent review request and a grievance/appeal has been submitted, treatment shall be continued without Member liability pending the outcome of the grievance/appeal (of the adverse determination or a final adverse determination).
- **Urgent concurrent review request**: While an expedited appeal is being reviewed as a result of a denial of an urgent concurrent review request, the treatment shall be continued without Member liability until the Member has been notified of the appeal decision.

First Level: Correspondence Department

The Correspondence Department will acknowledge the receipt of the member's appeal/grievance in writing, within **5 business days** of receipt of the request.
- State regulations require different timeframes to be adhered to depending on the level of appeal. Oxford notifies the initiator within the most stringent regulated timeframe.
- A full investigation of the substance of the grievance/appeal, including any aspects of clinical care, will be performed by a person or persons who were not involved in the initial determination, and is not the subordinate of any person involved in the initial determination.
- The Member will be given an opportunity to submit written comments, documents, medical records, photos, or other information relevant to the Member's appeal.

CT Products Only

Oxford will notify the member, or the member's authorized representative, that the Member is entitled to submit written material to be considered as part of Oxford's review of the appeal no later than 3 business days from receipt of the appeal/grievance. Oxford will provide the Member with the name, address and telephone number of the department who is coordinating the review of the appeal.

First Level Member Non-UM Grievance/Appeals Submission Timeframes

Member State	Timeframe
All states	All plans have **180 calendar days** from receipt of the Explanation of Benefit to submit an appeal for a Non UM decision. **Exception:** New Jersey Public Sector plans have **18 months** from receipt of the Explanation of Benefits to submit an appeal for Non UM decision.

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First Level Member Grievance/Appeals Decision Timeframes

Post-Service Appeals/Grievances

Member State	Timeframe
CT	1st level decisions are made within 20 business days of receipt of a Post-Service appeal/grievance. Oxford will notify the Member of the decision, in writing, within this timeframe. If Oxford is unable to render a decision within this timeframe due to circumstances beyond our control, the decision time period may be extended for an additional 10 business days. If an extension is needed, Oxford will notify the Member in writing of the extension and the reason(s) for the delay.
NJ	1st level decisions are made within 30 calendar days of receipt of a Post-Service grievance/appeal.
NY	1st level decisions are made within 30 calendar days of Oxford's receipt of a Post-Service appeal/grievance.

Pre-Service Appeals

Member State	Timeframe
CT	Decisions will be rendered and communicated to the Member within 20 business days from the receipt of an appeal/grievance for the request for services or treatment that has not yet been received. Oxford will notify the Member of the decision, in writing, within this timeframe. If Oxford is unable to render a decision within this timeframe due to circumstances beyond our control, the decision time period may be extended for an additional 10 business days. If an extension is needed, Oxford will notify the Member in writing of the extension and the reason(s) for the delay.
All Others	Decisions will not be rendered later than 15 days from the receipt of a grievance/appeal for the request for services or treatment that has not yet been received. Full documentation of the substance of the grievance/appeal and the actions taken will be maintained in a confidential file (paper or electronic). Written notification to the member will be issued within 1 working day of completing the review of the disposition of the appeal, and further appeal rights if appropriate.

Written Appeal Decisions

Written appeal decisions must include the following elements, when applicable:

Member State	Appeal Decisions Must Include the Following Elements
All States	• The specific reasons for the appeal decision in easily understandable language. • A reference to the clinical criteria, benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, as well as written notification that the member, upon request, is allowed access to and copies free of charge of relevant documentation regarding the member's appeal. Refer to Disclosure Policy. • A list of titles and qualifications of individuals participating in the appeal review (participant names do not need to be included in the written notification to members). • A list of titles and qualifications of individuals participating in the appeal review (participant names do not need to be included in the written notification to members). **Note**: Connecticut members only have 1 level of internal appeal for Non-UM determinations. At this point, the member has the right to file a civil action (see next bullet). • After all levels of appeals have been exhausted, the member has the right to file a civil action under 502(a) of the Employee Retirement Income Security Act (ERISA). ERISA rights apply to all products except, individual contracts, or members of church or government groups.
CT	In addition to the above listed requirements for all states, CT appeal decisions must include the following elements: • A statement of Oxford's understanding of the Member's appeal/grievance; • Reference to the documents, communications, information and evidence or documentation used as the basis for the decision; • A statement that the covered person may receive from the health carrier, free of charge and upon request, reasonable access to and copies of, all documents, communications, information and evidence regarding the adverse determination that is the subject of the final adverse determination.

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Member State	Appeal Decisions Must Include the Following Elements
NJ	In addition to the above listed requirements for all states, NJ appeal decisions must include the following elements: • Information sufficient to identify the claim involved such as the date of service, the name of Your Provider, the claim amount (if applicable) as well as information on the availability, upon request, of the diagnosis code and its corresponding meaning and treatment code and its corresponding meaning; **Note**: Request for the above information following an Adverse Benefit Determination will be responded to as soon as possible and will not be considered a request for second-level appeal. • Information on the availability and contact information for the consumer assistance program at the Department of Banking and Insurance, which assists covered persons with claims and, internal and external appeals.

Second Level: Grievance Review Board

Grievance Review Board

The Grievance Review Board is the formal stage 2 process whereby any member or any provider acting on behalf of a member with the member's consent, who is dissatisfied with the results of the first level stage 1 appeal, shall have the opportunity to pursue his or her appeal by submitting a written appeal. The Grievance Review Board (GRB) is a team of Oxford employees not involved in the initial determination and who are not the subordinate of any person involved in the initial determination appointed for the express purpose of reviewing and resolving member appeals. When an appeal is clinical in nature, the GRB will include a licensed physician who did not review the issue at the First Level Appeal. If the appeal pertains to an administrative issue, individuals of a "higher level" than those who reviewed the First Level Appeal will resolve the Second Level Appeal.

Oxford will:
- Conduct a review of the appeal that does not give deference to the denial decision.
- Fully investigate the substance of the appeal, including any aspects of clinical care involved.

The member will be given an opportunity to submit written comments, documents, medical records, photos, or other information relevant to the member's appeal to the Grievance Review Board.

NJ Only

Oxford will acknowledge the receipt of your appeal within 10 business days of receipt. The acknowledgment will include the name, address and phone number of the individual designated to review your appeal and what additional information, if any, must be provided for us to render a decision.

Member State	Timeframe
CT	Second level internal appeals are not available for Connecticut members.
NJ	Members have **180 business days** to submit an Appeal to the Grievance Review Board from the notification of the first level appeal determination. **Exception:** New Jersey Public Sector Members have 18 months to submit an appeal to the Grievance Review Board from the notification of the first level appeal determination.
NY	Members have **60 business days** to submit an Appeal to the Grievance Review Board from the notification of the first level appeal determination

Decision Timeframe - for 2nd Level Member Grievance/Appeals

Note: Full documentation of the substance of the grievance and the actions taken will be maintained in an appeal/grievance file.

Post-Service Appeals/Grievances

Member State	Timeframe
CT	Second level internal appeals are not available for Connecticut members.
NJ	Second level decisions are made within **20 calendar days** of receipt of a Post-Service appeal/grievance.
NY	Second decisions are made within **30 calendar days** of receipt of a Post-Service appeal/grievance.

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Pre-Service Appeals

Member State	Timeframe
CT	Second level internal appeals are not available for Connecticut members.
All Other Plans	Decisions will not be rendered later than **15 days** from the receipt of a grievance/appeal for the request for services or treatment that has not yet been received. Written notification to the member will be issued within 5 business days (not to exceed 30 calendar days) of completing the review of the disposition of the appeal/grievance.

Written Appeal Decisions

Written appeal decisions must include the following elements, when applicable.

Member State	Appeal Decisions Must Include the Following
All States	• The specific reasons for the appeal decision in easily understandable language. • A reference to the clinical criteria, benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based. • Written notification that the member, upon request, is allowed access to and copies free of charge of relevant documentation regarding the member's appeal. Refer to Disclosure Policy. • A list of titles and qualifications of individuals participating in the appeal review (participant names do not need to be included in the written notification to members). After all levels of appeals have been exhausted, the member has the right to file a civil action under 502(a) of the Employee Retirement Income Security Act (ERISA). ERISA rights apply to all products except, individual contracts, or members of church or government groups
NJ	In addition to the above listed requirements for all states, NJ written appeal decisions must include the following elements: • Any new or additional evidence or rationale, which was relied upon, considered or used in making the decision. • Information on the availability and contact information for the consumer assistance program at the Department of Banking and Insurance, which assists covered persons with claims and, internal and external appeals.

REFERENCES

CT Public Act 11-58 and CT Public Act 12-102

CT State Regulations

Department of Labor Regulations 29CFR 2560.503.1

N.J.A.C. 11:24 & N.J.A.C. 11:24A

NCQA Health Plan Accreditation Standards

NJ Prompt Pay law

NJ State Regulations

NY State Regulations

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
12/01/2016	• Reformatted and reorganized policy; transferred content to new template (no change to policy guidelines) • Archived previous policy version APPEALS 018.9 T0

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