Important Terms.

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

An adverse benefit determination includes:

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

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

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

A **complaint** is an expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) calendar day of receipt. A complaint must be submitted in writing or over the phone **within 30 calendar days** of the event causing dissatisfaction. The member, legal guardian of a minor member, provider or an authorized representative acting on the member's behalf may file a complaint.

Grievance Process.

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

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

The member, legal guardian of a minor member, provider or an authorized representative acting on the member's behalf can file a grievance at any time. If the grievance is called in, we will let the caller know we've received the grievance unless we are asked to confirm receipt in writing. If the grievance is written to us, we will send a letter within five (5) calendar days to say we received the grievance. We will review the grievance and send notice of our decision within thirty (30) calendar days of receipt or as expeditiously as the member's health condition requires. If the requestor asks for more time or we need more information and the delay is in the member's interest, the time frame may be extended by up to 14 days. If we ask for more time, we will try to call the requestor and we will write to say why we need more time.

What can I do if I need a fast decision? If a fast decision is needed because the member's health is at risk, the member, legal guardian of a minor member, provider or authorized representative may file an **Expedited Grievance** by calling member services at **1-800-992-9940**, TTY **711.**

To file a grievance, call Member Services at 1-800-992-9940, TTY 711 or write us at:
Grievance and Appeals
P.O. Box 5032
Kingston, NY 12402-5032

If you need assistance, please call member services at 1-800-992-9940, TTY 711

- 7:30 a.m. – 5:30 p.m. CT Monday – Friday
- 7:30 a.m. – 8:00 p.m. CT on Wednesday
- 8:00 a.m. – 5:00 p.m. CT the first Saturday and Sunday of each month.

Use the form below or in the member handbook to file a grievance. We must have written your permission if anyone other than the member or legal guardian of minor member will be filing a grievance on the member's behalf.

UnitedHealthcare will call with our decision within 72 hours of the expedited request. This time frame may be extended up to 14 days. If the requestor asks for more time or we show that there is need for additional information and the delay is in the member's interest, the time frame may be extended. If we ask for an extension, we will give written notice of the reason. The member/legal guardian of a minor member will receive a decision letter in writing. The letter will give the reason for our decision and what to do about the decision. If we decide that the grievance does not need a fast decision based on the rules, we will call. The grievance will be handled within 30 calendar days. We will also send a letter within two (2) days of the call. After the grievance is reviewed, we will send a letter with our decision.

Appeal Process.

What is an appeal?
An appeal is a request for a review by UnitedHealthcare Community Plan of an Adverse Benefit Determination.

Members and legal guardians of minor members have a right to request appeal of an adverse benefit determination. **The member, legal guardian of the member, provider, or other authorized representative acting on the member's behalf must file your appeal within 60 calendar days of receiving UnitedHealthcare's Notice of Adverse Benefit Determination.**

When the appeal is filed, we will send a letter within ten (10) calendar days saying we received the appeal. We will review the appeal and send our decision within thirty (30) calendar days. If the requestor asks for more time or we show there is a need for more information and the delay is in the member's interest, the time frame may be extended up to 14 days. If we ask for more time, we make a reasonable attempt to call and we send a letter to explain why we need more time.

An appeal can be submitted if the member has been getting medical care and your health plan reduces, suspends, or ends the service. In order for medical care not to stop while the decision is being appealed, the appeal must be received within ten (10) calendar days from the date of the Notice of Adverse Benefit Determination and with a request to not to stop the service while the appeal is being reviewed. If the appeal is denied, the member or legal guardian of a minor member may have to pay for the medical care received during this time.The benefits will continue until one of the following occurs:

- Appeal request is withdrawn.
- Appeal was not requested within 10 calendar days from the date of the notice of adverse benefit determination.
- The authorization for services has expired or service authorization limits are met.
- An appeal decision is issued that is adverse to the member.

To file an appeal, call Member Services at 1-800-992-9940, TTY 711 or write to us at:
Grievance and Appeals
P.O. Box 5032
Kingston, NY 12402-5032

If you need help writing or filing an appeal, call Member Services at 1-800-992-9940, TTY 711.

- 7:30 a.m. – 5:30 p.m. CT Monday – Friday
- 7:30 a.m. – 8:00 p.m. CT on Wednesday
- 8:00 a.m. – 5:00 p.m. CT the first Saturday and Sunday of each month.

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

Use the form below or in the member handbook to file an appeal. We must have written permission if anyone other than the member or legal guardian of a minor member will be filing the appeal on the member's behalf.

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

What can I do if I need immediate care?

If the member, legal guardian or a minor member or member's doctor wants a fast decision because member's health is at risk, call Member Services at **1-800-992-9940**, TTY **711** for an **expedited review** of a Notice of Adverse Benefit Determination. A member letter is not required for a fast decision once the requestor calls Member Services. UnitedHealthcare Community Plan will call with our decision within 72 hours of getting the request for an expedited review. This time frame may be extended up to 14 days if member or legal guardian of a minor member asks for the extension or we show that there is need for additional information and the delay is in the member's interest. If we ask for an extension, we will make a reasonable attempt to call and we send a letter to explain why we need more time. If we decide that the appeal does not need a fast decision based on the rules, we will call. The appeal will be handled within 30 calendar days. We will also send a letter within two days of calling. The member will receive a letter telling the reason for our decision and what to do about the decision.

How do I file a State Fair Hearing request?

If the member or legal guardian of minor member disagrees with an adverse benefit determination by UnitedHealthcare Community Plan, there can be an appeal directly to the Mississippi Division of Medicaid (DOM) by filing a request for a State Fair Hearing.

An appeal to DOM can occur after appeal rights with UnitedHealthcare Community Plan have been exhausted.

A State Fair Hearing must be filed within one hundred and twenty (120) calendar days of the receipt of the final decision from UnitedHealthcare Community Plan.

For information on requesting a State Fair Hearing, call 601-359-6050 or 1-800-421-0488 or write to:
Division of Medicaid Office of the Governor
Attn: Office of Appeals 550 High Street, Suite 1000
Jackson, Mississippi 39201

Continuation of benefits. If the member has been getting an ongoing service or item that is being reduced, changed or stopped, these benefits may continue if:

1. The appeal is received within 10 days from the date the member received UnitedHealthcare Community Plan's Notice of Adverse Benefit Determination.
2. Member or representative requests that the service be continued.

The service may be continued through the appeal and State Fair Hearing process unless the appeal is discontinued, member or representative fails to request a State Fair Hearing and continuation of benefits, or the prescription for the service ends. If a State Fair Hearing is requested and requestor wants member's benefits to continue, the request must be file within 10 days from the date our decision is received. If the State Fair Hearing finds that UnitedHealthcare Community Plan's decision was right, member or legal guardian or minor member may be responsible for the cost of the continued benefits.

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

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

Grievance and appeal form.

Member's name_____

ID #_____

Address_____

Telephone number (Home) _____ (Work) _____

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

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Mail to:

Grievance and Appeals
P.O. Box 5032
Kingston, NY 12402-5032