UnitedHealthcare Community Plan
GRIEVANCE AND APPEAL PROCESS

Who do I call for help at my health plan?

If you need help, call 1-877-542-8997, or for TTD/TTY, call 711. We will keep your information private. If you do not speak English, we can help. If you need any information in a language other than English, call us at 1-877-542-8997 or TTD/TTY 711. We will provide language assistance at no cost to you.

To file a grievance or appeal, contact: **UnitedHealthcare Community Plan**	
Attention: Appeals and Grievances	**Web:** myUHC.com
Address: P.O. Box 31364	**Phone:** 1-877-542-8997
City/State/Zip: Salt Lake City, UT 84131-0364	**Fax:** 1-801-994-1082

If you are a client with behavioral health needs, the Behavioral Health Advocate is someone that can help you with questions and filing grievances and appeals. If you need information about how to contact your local Behavioral Health Advocate, call 1-877-542-8997 or go to UHCCP.com/wa/ahe.

GRIEVANCE PROCESS: How do I report a complaint?

You or your authorized representative have the right to file a complaint. This is called a grievance. We will help you file a grievance. Grievances are complaints about:

- The way you were treated,
- The quality of care or services you received,
- Problems getting care,
- Billing issues.

If you need help filing a grievance, call 1-877-542-8997. Or for TTD/TTY, call 711 We will let you know we received your grievance within two business days. We will investigate and resolve your grievance within 45 calendar days and tell you how it was resolved. If we need more time, we will notify you and/or your authorized representative in writing. You have the right to appeal an adverse decision (if any made) by us.

STANDARD AND EXPEDITED APPEAL PROCESS: How do I request the review of a denied service or referral?

An appeal is a request to have us review a denied service or referral. You can appeal our decision if a service was denied, reduced, or ended early. Below are the steps in the appeal process:

STEP 1: UnitedHealthcare Community Plan Standard and Expedited Appeal
STEP 2: State Administrative Hearing
STEP 3: Independent Review
STEP 4: Health Care Authority (HCA) Board of Appeals Review Judge

Continuation of Services During the Appeal Process

If you want to keep getting previously approved services while we review your appeal, you must file your appeal within 10 calendar days of the date on your denial letter. If the final decision in the appeal process agrees with our decision, you may need to pay for services you received during the appeal process.

STEP 1 – UnitedHealthcare Community Plan **Standard and Expedited Appeal: How do I ask for an appeal?**

You have the right to file an appeal. You may choose someone, including a lawyer or provider, to represent you and act on your behalf. You must sign a consent form allowing this person to represent you. UnitedHealthcare Community Plan does not cover any fees or payments to your representatives.

That is your responsibility. You also have the right to receive assistance from Behavioral Health Advocates for filing the appeal.

You or your authorized representative have 60 calendar days after the date of UnitedHealthcare Community Plan's denial letter to ask for an appeal. An appeal may be requested over the phone, in person, or in writing. You have the right and the opportunity to submit written comments, documents and other additional information relevant to the appeal. Information to support your appeal may be submitted over the phone, in writing, or in person. Within five calendar days, we will let you know in writing that we got your standard appeal, or 72 hours for an expedited appeal. UnitedHealthcare Community Plan can help you file your appeal. If you need help filing an appeal, call 1-877-542-8997.

STEP 1: Ask for an appeal with UnitedHealthcare Community Plan
Phone: 1-877-542-8997; **Fax:** 1-801-994-1082
Address: P.O. Box 31364, Salt Lake City, UT 84131-0364
Online: myUHC.com

You can ask a health carrier to identify the experts who were consulted about the adverse benefit determination – even if the expert's advice was not used to make the determination. The carrier is not required to identify the expert by name or provide their address. The carrier can instead provide the expert's job title and specialty, board certification status or other information related to their qualifications and also state whether or not they are employed by the carrier.

Before or during the appeal, you or your representative may request copies of all the documents in this appeal file, and the guidelines or benefit provisions used to make the decision. These will be sent to you free of charge. We will resolve your appeal as quickly as your health requires. UnitedHealthcare Community Plan will send you our decision in writing within 14 calendar days, unless we tell you we need more time. If we need more time, we will notify you and/or your authorized representative in writing. Our review will not take longer than 28 calendar days. We will keep your appeal private.

If you or your provider wants a fast decision because your health is at risk, call 1-877-542-8997 for a quick (called "expedited") review of the denial. You may ask for a quick review if your physical or mental health is at serious risk, or it involves a mental health drug authorization. UnitedHealthcare Community Plan will contact you with our decision within 72 hours of getting your request for an expedited review.

If you ask for an expedited appeal, but UnitedHealthcare Community Plan decides your health is not at risk, we will follow the standard appeal timeframe. We will send you a letter telling you the decision and the reason for the change within two calendar days of your appeal request.

The expedited timeframe may be extended up to 14 calendar days if additional information to process your appeal is needed, and the delay is in your best interest. If UnitedHealthcare Community Plan extends the timeframe, we will send you a letter within two calendar days of your appeal request telling you why the extension is needed. You can also ask for an extension.

STEP 2 – State Administrative Hearing: How do I ask for a legal review?
If you disagree with UnitedHealthcare Community Plan's appeal decision, you can ask for a State Administrative Hearing. You must complete UnitedHealthcare Community Plan's appeal process

before you can have a hearing. You must ask for a hearing within 120 calendar days of the date on the appeal decision letter stating the denial was upheld. When you ask for a hearing, you need to say what service was denied, when it was denied, and the reason it was denied. Your provider may not ask for a hearing on your behalf.

STEP 2: Ask for a State Administrative Hearing
Contact the Office of Administrative Hearings (OAH)
Phone: 1-800-583-8271
Address: P.O. Box 42489, Olympia, WA 98504-2489

You may consult with a lawyer or have another person represent you at the hearing. If you need help finding a lawyer, check with the nearest Legal Services Office or call the NW Justice CLEAR line at 1-888-201-1014 or visit their website at www.nwjustice.org.

You may ask for a quick decision if your health is at risk. A judge will make a decision within four working days after receiving the request. If the judge decides your health is not at risk, OAH will call you and send you a letter within four working days of the request. Your hearing will change to the standard timeframe.

STEP 3 - Independent Review: How do I ask for an Independent Review?
An Independent Review is a review by a doctor or specialist who does not work for UnitedHealthcare Community Plan. If you do not agree with the decision from the State Administrative Hearing, you can ask for an Independent Review within 21 calendar days of the hearing decision or you may go directly to Step 4. Call 1-877-542-8997 for help. You may ask for a quick decision if your health is at risk. Any extra information you want reviewed must be given to us within five working days of asking for the Independent Review. If you ask for this review, your case will be sent to an Independent Review Organization (IRO) within three working days. You do not have to pay for this review. UnitedHealthcare Community Plan will let you know the decision.

STEP 3: Ask for an Independent Review
Contact UnitedHealthcare Community Plan
Phone: 1-877-542-8997
Fax: 1-801-994-1082
Address: P.O. Box 31364, Salt Lake City, UT 84131-0364

STEP 4 – Health Care Authority (HCA) Board of Appeals: How do I ask for another legal review?
You can ask for a final review of your case by the HCA Board of Appeals Review Judge. You must ask for this within 21 calendar days after the IRO decision is mailed. The decision of the HCA Board of Appeals is final.

STEP 4: Ask for a review by the HCA Board of Appeals
Phone: 360-725-0910; Toll-free: 1-844-728-5212
Fax: 360-507-9018
Address: P.O. Box 42700, Olympia, WA 98504-2700

OTHER INFORMATION

Billed for services: If you get a bill for health care services, call 1-877-542-8997.

Second Opinion: At any time, you can get a second opinion about your health care or condition. Call 1-877-542-8997 to find out how to get a second opinion.

Non-Covered Benefit

Exception to Rule: You or your provider may ask UnitedHealthcare Community Plan to approve a service that is not a covered benefit. For adults, this is called an Exception to Rule (ETR).

- It must be asked for before you get the service.
- Your provider must give us documentation that your condition is different from most people.
- No other covered, less costly service will meet your need.
- The request must fall within accepted standards of good medical practice and be submitted in writing within 90 days of the written notification of the non-covered service being denied.
- A decision will be made within 15 days of receiving the ETR request. If we need more information to make the decision, that information must be provided within 30 days of our request.
- You can ask for an appeal at the same time you or your provider asks for an Exception to Rule**.**

ETR decisions are final and cannot be appealed.

Limitation Extension: Your provider may ask UnitedHealthcare Community Plan to approve more services for you than your benefit package allows. It may be more in scope, number, length of time, or how often a service is provided. An example is more adult physical therapy visits than the 12 visits the benefit allows. This is called a Limitation Extension (LE). To be approved, it must meet the rules in Washington Administrative Code (WAC) 182-501-0169:

- The extension must be asked for before you get more of the service.
- There must be documentation that your condition is improving due to the services you have already received.
- You must show that your condition will likely continue to improve with more services, and that it will likely worsen without continued services.

You can ask for an appeal at the same time as your provider asks for a Limitation Extension.

Funding for some services is limited by available money: Some services are paid for with State-only or Federal block grant dollars. If the State-Only or block grant money runs out, we cannot approve the service for you even if we agree the services are needed. There is no appeal process if a service is ended due to State-Only or block grant money running out. You will be notified if this situation applies to you.