Material pulled from Provider Manuals on line at each MCO website (source document links embedded)

This information (in more simplified terms) is also included in the Member Manuals, also on line for each MCO

Amerigroup

https://providers.amerigroup.com/ProviderDocuments/KSKS_Prov_Manual.pdf

3.1. Provider Grievance Procedures

You can submit verbal or written grievances. Supporting documentation should accompany the grievance.

Grievances are resolved fairly and are consistent with our policies and covered benefits. You will not be penalized for filing a grievance.

3.2. Verbal Grievance Process

Submit verbal grievances to:

Provider Services at 1-800-454-3730

The Amerigroup Kansas health plan

Your local Provider Relations representative

All provider calls will be answered immediately during normal business hours. Inquiries will be resolved and/or results will be communicated to the provider within 30 business days of receipt. If inquiries are not resolved within 30 days, Amerigroup will document the reasons why the issues go unresolved; however, the issue will be completely resolved within 90 days.

3.3. Written Grievance Process

Submit a grievance in writing by letter or fax to:

Amerigroup Kansas

9225 Indian Creek Parkway, Building 32

Overland Park, KS 66210

Fax: 913-563-1680

You can also appear in person at the following office to submit a grievance:

Amerigroup Kansas

9225 Indian Creek Parkway, Building 32

Overland Park, KS 66210

8.4. Member Grievances

Our members have the right to say they are dissatisfied with Amerigroup or a provider's service and operations.

Only a member or a member's authorized representative with the member's written consent may file a grievance.

A member can file a grievance orally by calling Member Services at 1-800-600-4441. He or she can also file a grievance by mail. Any supporting documents must be included. Grievances should be sent to:

Administrative Review and Grievance Department

Amerigroup Kansas

9225 Indian Creek Parkway, Building 32

Overland Park, KS 66210

Member grievances do not involve:

Medical management decisions

Interpretation of medically necessary benefits

Adverse determinations

These are called appeals and are addressed in the appeals sections of this manual.

We will acknowledge receipt of each grievance, either orally or in writing, within five days.

We investigate each grievance and all of its clinical aspects. Urgent or emergent grievances are resolved within 24 hours of receipt. We inform the member, investigate the grievance and resolve it within 30 calendar days from the date we received the grievance. This includes:

For clinical issues, a written disposition of the grievance within five business days of determination

For nonclinical issues, a written or oral disposition of the grievance within five business days of determination

Members do not have the rights to hearings in regard to the dispositions of grievances.

We will notify the member in writing of:

The names(s), titles(s) and, in the case of a grievance with a clinical component, qualifying credentials of the person or persons completing the review of the grievance

The disposition of the grievance

Policies and procedures regarding the decision

The right to further remedies allowed by the law

How the grievance process may be continued with KDHE if the member does not agree with the resolution after the member has exhausted all levels of our grievance process

How the member may be advised or represented by a lay advocate, attorney or other representative as chosen by the member and agreed to by the representative

8.5. Member Appeals

A member, a member's authorized representative or a provider acting on behalf of a member with the member's written consent may file an appeal:

For an appeal of standard service authorization decisions, a member must file an appeal, either orally or in writing, within 30 calendar days of receiving the Amerigroup Notice of Action. This also applies to a member's request for an expedited appeal.

For an appeal for termination, suspension or reduction of previously authorized services when the member requests continuation of such services, the member must file an appeal within 10 calendar days of receiving the Amerigroup mailing of the notice of action.

Oral inquiries seeking to appeal actions shall be treated as appeals and be confirmed in writing within 10 days, unless the members or providers request expedited resolutions.

We will inform the member of the limited time he or she has to present evidence and allegations of fact or

law with expedited resolution. And we also ensure that no punitive action will be taken against a provider

who supports an expedited appeal.

Our goal is to handle and resolve every appeal as quickly as the member's health condition requires. Our

established time frames are:

Standard resolution of appeal and for appeals for termination, suspension or reduction of previously authorized services: 14 calendar days from the date of receipt of the appeal. We can extend this timeframe if the member requests extension or if Amerigroup shows the State that there is a need for additional information and how the delay is in the member's interest. We will notify the member of the reason for the extension. The extension cannot delay the decision beyond 28 calendar days of the request for appeal

Expedited resolution of appeal, including notice to the affected parties: no longer than three calendar days from receipt of the appeal, except for those appeals related to an ongoing emergency or denial of continued hospitalization, which will be resolved within 1 business day of receipt of the appeal.

Appeals relating to an ongoing emergency or denial of continued hospitalization: no longer than one business day after receiving the member's request for expedited appeal. This timeframe cannot be extended.

The notice of the resolution of the appeal shall be in writing. For notice of an expedited resolution, we will

also make reasonable efforts to provide oral notice. We will include the date completed and reasons for the

determination in easily understood language. A written statement of the clinical rationale for the decision,

including how the requesting provider or enrollee may obtain the utilization management clinical review or

decision-making criteria, will be issued.

If an appeal is not wholly resolved in favor of the member, the notice will include:

The right for our member to request a state fair hearing and how to do so

The right to receive benefits while this hearing is pending and how to request them

Notice that the member may have to pay the cost of these benefits if the state fair hearing officer upholds the Amerigroup action

Expedited appeals

Our expedited appeal process is available upon the member's request or when a provider indicates a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain or regain maximum function. The member or provider may file an expedited appeal either orally or in writing.

No additional written follow-up on the part of the member or the provider is required for an oral request for an expedited appeal.

No punitive actions are taken against providers who request expedited resolutions or support members' appeals.

Amerigroup will resolve each expedited appeal and provide notice to the member as quickly as the member's health condition requires and within three calendar days after receipt of the expedited appeal request.

If your request is deemed to be a nonexpedited issue, our standard timeline for appeals will apply and the member will receive notification that the appeal is being transferred to the standard appeal process.

Members have rights to file grievances regarding our denial of requests for expedited resolutions. We will inform members of their right to file grievances in the notices of denial.

Continuation of benefits

We are required to continue a member's benefits while the appeals process or the state fair hearing is pending if all of the following are true:

The appeal is submitted to us on or before the latter of the two: within 10 calendar days of our mailing the notice of action or the intended effective date of our proposed action

The appeal involves the termination, suspension or reduction of a previously authorized course of treatment

Services were ordered by an authorized provider, as applicable

The original period covered by the original authorization has not expired

The member continues to be enrolled to a category of eligibility for which the service is a benefit

The member requests an extension of benefits

If the decision is against the member, we may recover the cost of the services the member received while

the appeal was pending.

Sunflower

http://www.sunflowerstatehealth.com/files/2013/01/Sunflower_Provider-Manual_Final-Revised-04-04-13.pdf?1094d2

GRIEVANCES AND APPEALS PROCESS

Member Grievances

A Member grievance is any expression of dissatisfaction about any matter. Grievances may include, but are not limited to: denial of service, partial denial of service, not given clear and accurate information from staff, lack of action being taken on a case, the quality of care or services provided to a Member, any aspects of interpersonal business relationships such as the rudeness of a Sunflower State employee or provider, or failure to respect the Member's rights. Members may access the Office of Administrative Hearings (OAH) State Fair Hearing process at any time except when an expedited appeal is requested. Members must exhaust Sunflower's expedited appeal process prior to accessing the expedited State Fair Hearing process.

Receipt and Documentation. Members, authorized representatives acting on a Member's behalf, and providers, with the Members' written consent, may file a grievance, within 180 days, orally by using our toll-free or TTY/TDD number, in person, in writing, via email or via the Secure Member Portal.

Grievances may be submitted to:
Sunflower State
Complaint and Grievance Coordinator
8325 Lenexa Drive
Lenexa, KS 66214
Phone: 1-877-644-4623
Fax: 1-866-491-1824

Acknowledgement. Staff receiving grievances orally will acknowledge the grievance and attempt to resolve it immediately. Staff will document the substance of the grievance. For informal grievances, defined as those received orally and resolved immediately to the satisfaction of the Member, representative or provider, the staff will document the resolution details. All oral or written grievances will be forwarded to the Complaint and Grievance Coordinator for tracking, written acknowledgment, and resolution. If resolved upon intake, the acknowledgement letter will include appropriate language advising of the resolution agreed upon. If not resolved at the time of intake, the Complaint and Grievance Coordinator will send a written acknowledgment letter within 10 business days of receipt. The Complaint and Grievance Coordinator will include a description of the grievance procedure including timeframe for resolution.

Investigation. The Complaint and Grievance Coordinator will conduct an initial review, which may include contacting the Member for additional information or clarification of the issue and gathering applicable documentation from other Sunflower State departments. Clinical issues, including grievances filed as a result of a service denial, partial service denial or a decision to deny a request for an expedited appeal resolution, are forwarded to the Medical Management Department for investigation or review by a physician or other appropriate clinician. If the grievance involves a quality of care issue, it is escalated to the Director, Quality Improvement for review, resolution and inclusion in the quality of care investigation process. Matters involving privacy concerns or potential fraud and abuse are forwarded to the Sunflower State Compliance Officer for resolution. The Compliance Officer will also determine whether the issue should be forwarded to KDHE, KDADS, and Kansas' Medicaid Fraud Control Unit (MFCU), and will report credible cases of Member fraud, waste, and abuse within 24 hours. If the Member has requested disenrollment, Sunflower State's Complaint and Grievance Coordinator will provide the Member with information on the disenrollment process and direct the Member to the appropriate State contact. Sunflower State's Complaint and Grievance Coordinator will also inform the Member how to access a State Fair Hearing if the Member is dissatisfied with denial of a Member's request to transfer or disenroll from the plan. If the request for disenrollment includes a grievance, the grievance will be handled separately via the grievance process described herein.

Notice of Resolution. The Complaint and Grievance Coordinator will resolve the grievance as expeditiously as possible, not to exceed twenty (20) days from receipt of the grievance, and send a written notice of the resolution to the Member. Our internal goal is to resolve grievances within 10 business days. Regardless of the outcome, Sunflower State will not discriminate or retaliate against a Member, a Member's representative or a provider, for filing a grievance or appeal or requesting an OAH State fair hearing.

Member Appeal Process. An appeal is defined as a request for the review of an Action taken by a health plan. The definition of an Action includes: the denial or limited authorization of a requested service, including the type or level of service; reduction, suspension or termination of a previously authorized service; denial, in whole or in part, of payment for a service; failure to provide services in a timely manner including failure of Sunflower State to act within the required timeframes; or a request for reconsideration of a previously resolved grievance. Members will have 30 calendar days from the date of the receipt of the *Notice of Action* to request an appeal. Members, the legal representative of a deceased Member's estate, or a Member's authorized representative with written consent from the Member acting on behalf of the Member, may file an appeal orally or in writing. Appeals may be directed to:

Sunflower State
Appeals Coordinator
8325 Lenexa Drive
Lenexa, KS 66214
Phone: 1-877-644-4623
Fax: 1-866-491-1824

Providers filing an appeal on behalf of a Member will require the Member's written consent, other than in the case of an expedited appeal request. Oral or written requests to review an Action will be treated as an appeal. An oral appeal request must be followed by a written, signed appeal; however, if the appeal request is received orally, the oral receipt date will be considered the initial receipt date of the appeal. Expedited requests do not require written follow up, but Sunflower State's Appeals Coordinator will inform the Member of the limited time available to present evidence, either in person or in writing. When received, any additional documentation related to the appeal is date-stamped and included in the file for review.

Continuation of Benefits. Sunflower State will continue a Member's benefits through the appeal resolution process if the appeal was filed within 10 calendar days of the Notice of Action or the intended effective date of a proposed action and the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized provider; the original period covered by the original authorization has not expired and the Member requested an extension of benefits. If these conditions are met, benefits will be continued until at least one of the following occurs: the Member withdraws the appeal or the appeal decision is rendered and the Member does not request a continuance within the designated timeframe. If the Member, or their authorized representative, requests an extension of the services, but the authorized units of service have already been exhausted, Sunflower State may not extend the benefits pending the outcome of the appeal.

If a Member requests an extension of benefits pending an OAH fair hearing, Sunflower State will continue or reinstate the benefits until one of the following occurs: the Member withdraws the request for hearing; it is determined the Member did not request a fair hearing within 10 days from the adverse decision; a State Fair Hearing officer issues a decision adverse to the Member; or the authorization or service limits are met.

Acknowledgement. The Appeals Coordinator will document written or oral appeal requests within one business day of receipt. The content of the appeal, including all clinical aspects involved and any actions taken will be documented. The Appeals Coordinator will send the Member or authorized representative an acknowledgement letter within 3 business days of receiving the request that will include the subject of the appeal, explanation of the appeal process, and the Member's rights. The Member's right will include the right to submit comments, documents, or other evidence relevant to the appeal in person or in writing and the right to access the OAH state fair hearing process at any time during the appeal process.

Medical Reviewer. A physician with appropriate clinical expertise will review appeal requests involving clinical issues or any medical necessity decisions. The individual will be a clinical peer of the same or similar specialty, who is not a subordinate of the individual who made the initial adverse determination, and who was not involved in the initial determination or any prior decision-making. In addition, the individual will not be a Sunflower State network provider.

Resolution. Sunflower State will resolve standard appeals and provide notice within 14 calendar days of receipt, or sooner, if the Member's health condition requires. The resolution timeframe may be extended up to 14 calendar days if the Member requests the extension. If Sunflower

State requires an extension to obtain additional information that would be in the best interest of the Member, Sunflower State will obtain permission from KDHE, KDADS and the Member. We will provide the Member with written notification of the reason for the delay for extensions not requested by the Member. Appeal resolution notice will include, but is not limited to, the appeal decision and reasons for the decision in easily understood language, reference to the protocol or criterion on which the decision was based, notification of the Member's rights, including the right to receive a copy of the actual protocol or criterion on which the decision was based, a list of titles and qualifications of individuals participating in the appeal review.

For any adverse decision, the notice will also include the following information: the Member's right to request an OAH State fair hearing within 30 days; instructions on how to request an OAH fair hearing; how to request a continuance of previously authorized benefits pending a hearing, including the 10 day timeframe for requesting the continuation; information regarding the Member's liability for the cost of any continued benefits if Sunflower State's decision is upheld; the Member's right to represent him/herself or use legal counsel, a relative, friend or a spokesperson; the specific regulation, Federal or State law that supports the action; and the Member's rights to request and evidentiary hearing if one is available.

Expedited Appeal Process. During the appeal process, a Member or provider may request, orally or in writing, an expedited appeal of an Action, if it could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function. An oral expedited appeal request does not need to be followed by a written request for the expedited appeal. The Appeals Coordinator will contact the Member and notify him/her of the limited time available to submit any supporting information or evidence and how to submit the information for consideration. In addition, the Member will be notified that they must exhaust Sunflower State's expedited appeal process prior to filing a State Fair Hearing with OAH. The Appeals Coordinator will immediately gather all supporting documentation for expedited appeal requests and forward the information to a Medical Director (MD) with the same or similar specialty, who was not involved in any previous level of review. Prior to issuing a final determination, the MD will also contact the requesting provider to obtain any additional information the provider, or Member, would like the MD to consider.

Requests related to an ongoing emergency, continued hospitalization, or other health care services for a Member who has received emergency services but has not been discharged will be processed within 24 hours. For all other expedited appeal requests, the MD will render a decision within 72 hours of receiving the request, or as expeditiously as the Member's condition warrants. The MD or Appeals Coordinator will provide prompt verbal notice of all decisions to the provider and Member within the 72 hour timeframe that will include the decision outcome. The Appeals Coordinator will send written notification within 48 hours of the expedited decision. In the event of an adverse Action, the verbal and written notices will include information on how the Member can access an expedited fair hearing from OAH.

If a request for an expedited appeal resolution is denied, Sunflower State will transfer the appeal to the standard resolution process and the Member will be notified with prompt oral notice of the denial of the expedited request. Written notice will be sent to the Member within two calendar days. The notice will not be considered an Action and a Member can file a grievance in response to the decision.

Access to OAH Fair Hearings. Sunflower State's Appeals Coordinator will notify a Member during the appeal process of their right to access the OAH fair hearing process at any time during the appeal or following a final adverse appeal notice. As outlined previously, a Member will not

have a right to an *expedited* OAH fair hearing unless the Member has exhausted Sunflower State's expedited appeal process. If a Member requests an OAH fair hearing, Sunflower State will submit the electronic form to the appropriate OAH office within five calendar days of the Member's request. Once Sunflower State receives notice of the fair hearing date, in accordance with OAH's fair hearing requirements, the Appeals Coordinator will prepare an evidence package and send a copy to both OAH and the Member within five calendar days of the receipt of the notice. If OAH reverses the decision from Sunflower State, Sunflower State will promptly authorize and coordinate services with the Member and the provider to ensure services are rendered. If Sunflower State's decision is reversed and services were already rendered, Sunflower State will ensure payment of those services.

To request a hearing from the Department of Social and Health Services contact:
Office of Administrative Hearings
1020 Kansas Avenue
Topeka, KS 66612
Phone: 1-785-296-2433

Provider Grievances and Appeals

Grievance. A Grievance is a verbal or written expression by a provider regarding dissatisfaction or dispute with any of the following: policies, procedures or any aspect of Sunflower State's administrative functions; handling of Notice of Proposed Actions or Explanation of Payments; claim adjudication, to include the amount reimbursed or a denial of payment for a particular service.

Sunflower State's Provider Grievances Coordinator (PGC) serves as the primary contact and coordinates on a daily basis with Provider Service Representatives, Appeals Coordinator, Claims Department staff, the Medical Director, QI Director and other key clinical staff to ensure prompt communication with providers during the investigation of the grievance. The PGC sends an acknowledgement notice to the provider within 5 business days of receipt of the grievance. Depending on the nature of the grievance, the PGC will coordinate with multiple departments at Sunflower State and Centene to thoroughly investigate each grievance leveraging statutory, regulatory and state contractual provisions, Sunflower State' Provider Manual, policies and procedures, and other key claims payment rules. Upon final resolution, the PGC will summarize the findings and send a notice of resolution to the provider within 30 calendar days of receipt of the grievance.

In the event Sunflower State receives a provider grievance from a State agency, Sunflower State's VP of Compliance will coordinate with the PGC to investigate the grievance and identify a resolution. Sunflower State's VP of Compliance will send a written response to the State agency within the timeframes outlined in the original communication from the State agency. If the original communication does not specify a timeframe, Sunflower State will respond within 10 business days.

Appeals. An appeal is a verbal or written request by a provider to reconsider the disposition of a claim payment, contracting issue or termination from Sunflower State's network.

Acknowledgement. The PGC will document written or oral appeal requests within one business day of receipt. The content of the appeal, including all clinical aspects involved and any actions taken will be documented. The PGC will send the provider an acknowledgement letter within 5 business days of receiving the request that will include the subject of the appeal, explanation of the appeal process, including the right to submit comments, documents, or other evidence relevant to the appeal

Resolution. The PGC will coordinate with appropriate departments (claims, credentialing, network management, medical management and/or QI) to review the provider's appeal and reach a decision. Sunflower State will resolve a provider appeal within 30 calendar days of receipt and provide written notice of the appeal resolution to the provider. Appeal resolution notices will include, but are not limited to, the appeal decision and reasons for the decision and reference to the protocol or criterion on which the decision was based.

Final Medical Review. In the event a provider does not agree with a claims appeal, the provider can request, orally or in writing, a final medical claims dispute review. Sunflower State's PGC will document the request in CRM and send an acknowledgement to the provider within 5 business days. The PGC will gather all documentation on the case and send the dispute to a physician for further review. The physician will have appropriate clinical expertise to review provider appeal requests involving claim disputes related to a denial on the basis of medical necessity decisions. The individual will be a clinical peer of the same or similar specialty, who is not a Sunflower State network provider and who was not involved in the initial determination or any prior decision-making. Once the physician has reviewed the case, the PGC will summarize the resolution and send notice to the provider within 30 calendar days of receipt. If the provider is not satisfied with the final medical claims dispute review, the provider may utilize the Dispute Resolution process as defined in the Participating Provider Agreement or request a fair hearing appeal through the Office of Administrative Hearings.

United

http://www.uhccommunityplan.com/kansas-03.html

5.1 Filing a Member Grievance

Members or their authorized representative may file a grievance with UnitedHealthcare by calling Member Services toll-free
or by mailing a written grievance to the address provided in their Member Handbook. Welcome Packet materials and the
Member Handbook state that grievances should be filed directly with UnitedHealthcare and encourages members to follow
the grievance process appropriately. UnitedHealthcare date stamps written grievances, enters them into the grievance tracking
system and creates a case file. Verbal grievances are entered into the tracking system on the date of receipt and a case file
created. UnitedHealthcare acknowledges receipt of each member grievance and logs and tracks member name/identification
number; date grievance received/grievance acknowledged; grievance description code; staff assigned for disposition; disposition;
and disposition date.

5.2 Process for Resolving a Grievance

Member Services receives calls 24 hours a day, 7 days a week to address various issues, including member grievances. All calls
related to member grievances are logged into UnitedHealthcare's Escalation Tracking System(ETS). The majority of member
grievances are resolved during the initial call to UnitedHealthcare. The information is sorted to identify any potential quality of
care issues. If a call pertains to a potential quality of care issue, the member grievance is handled by the Quality Management

Department in accordance with all applicable quality management processes and procedures.
The Grievance Coordinator conducts preliminary research to verify the appropriate path of the grievance. The Grievance
Coordinator will research and processes the grievance for resolution. If it is necessary to involve other departments, the
Grievance Coordinator triages the grievance to the appropriate department and oversees the process until resolution is attained.
The Grievance Coordinator will close the case file in ETS with all applicable data. Members generally receive notification of
the grievance resolution within 20 calendar days, but no longer than 60 calendar days.

5.3 Member Appeal Process

When UnitedHealthcare makes a decision to deny or issue a limited authorization of a service authorization request, or
reduces, suspends or terminates a previously authorized service, we mail a Notice of Action to the member. Providers are also
informed via written notice of the decision to deny or reduce a service authorization request. We provide a Notice of Action
to the member as expeditiously as his/her health condition requires, but not later than 14 days following the receipt of the
authorization with a possible extension of up to 14 days if the member or provider requests an extension, or if we establish a
need for additional information and delay is in the member's best interest. If UnitedHealthcare does not make a decision within
the applicable time frames, a decision is made on the date that those time frames expire.

5.4 Filing an Appeal

An individual or a representative authorized in writing to act on the member's behalf may file an appeal in response to
the actions described above. The member has 30 calendar days from the date of the Notice of Action to file an appeal.
UnitedHealthcare will accept appeals in writing or verbally. UnitedHealthcare date stamps an appeal received, enters the
pertinent information into the appeals tracking system and creates an appeal case file to include available and relevant
information associated with the appeal. The Appeals staff acknowledges the receipt of each member appeal within 5 business
days for standard appeals and makes an effort to notify members verbally within (1) one calendar day for cases accepted as
expedited appeals.

5.5 Timeliness for Resolving an Appeal

UnitedHealthcare will resolve standard appeals and appeals for termination, suspension, or reduction of previously authorized
services within fourteen (14) calendar days after receipt of the appeal, unless UnitedHealthcare extends the initial 14 calendar
day time frame by up to 14 calendar days, with approval by the State, when UnitedHealthcare shows that there is need for
additional information and how the delay is in the Member's interest. UnitedHealthcare will expedite resolution of an appeal
if, according to the information provided by the member or as indicated by a provider filing an appeal on the member's behalf,
the standard resolution time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain
maximum function. Under such circumstances, UnitedHealthcare will resolve the expedited appeal within (3) business days

unless the investigation and resolution of an appeal is related to an ongoing emergency or denial of continued hospitalization
not later than one (1) business day after receiving the Member's request for expedited appeal is received. If the expedited appeal
request is denied, the appeal will be transferred to the standard appeal process. UnitedHealthcare will make every effort to
contact the member orally to notify them of the denial and provide written notice of denial, including the member's right to file
a grievance regarding UnitedHealthcare's denial of a request for expedited resolution.

5.6 Process for Resolving an Appeal

After the appeal has been logged into the tracking system and the acknowledgement letter has been sent, the appeal is assigned to an
Appeals Representative. Member benefits continue until a hearing decision is rendered if the:

- Member files an appeal before the later of 10 days from the mailing of the Notice of Action or the intended date of UnitedHealthcare's action;
- Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment or the appeal involves a
denial and the physician asserts that the requested service/treatment is a necessary continuation of a previously authorized service;
- Services were ordered by an authorized provider; and the member requests a continuation of benefits.

No punitive action is taken against a provider who either requests an expedited resolution or supports a member's appeal.
UnitedHealthcare provides each member, or member's representative, a reasonable opportunity to present evidence and allegations of
fact or law in person or in writing. The member is informed of the limited time available in cases involving expedited resolution. Any
information received during the resolution process is date stamped and incorporated into the case file. UnitedHealthcare provides
members an opportunity to examine the appeal file, including medical records and other documents considered by UnitedHealthcare
during the resolution process. Unless the appeal involves a denial based on lack of medical necessity or otherwise involves clinical
issues, the Appeals Representative researches and adjudicates the appeal. For clinical appeals, the Appeals Representative assembles
relevant background information from UnitedHealthcare's prior authorization and claims systems, obtains relevant clinical information
and forwards the matter to a health care professional with clinical expertise in treating the enrollee's condition or disease that was not
involved in any decision-making or previous review surrounding the action or appeal.
If the matter requires review by another UnitedHealthcare department, the Appeals Representative requests that a designated subject
matter expert in the department address specific issues necessary to resolve the appeal. The Appeals Representative may contact the
member or the member's treating provider to obtain information necessary to resolve the appeal. Upon completion of this process,
the Appeals Representative or designee provides verbal notice of UnitedHealthcare's decision for an expedited resolution and issues a
written Notice of Appeal Resolution for both expedited and standard resolutions.
The Notice of Appeal Resolution contains the date of resolution, reasons for the determination in easily understood language, and
a written statement of the clinical rationale for the decision, including how the requesting provider or enrollee may obtain the
Utilization Management clinical review or decision making criteria; and for appeals not resolved wholly in favor of the member:

(1) The member's right to request a fair hearing at any step in the appeals process (including the requirement that the member must file
the request for a hearing no later than 30 calendar days from the date of the Notice of Appeal Resolution) and how to make the request;
(2) Include information on the enrollee's right to receive services while the hearing is pending and how to make the request; and
(3) Information explaining that the member may be held liable for the amount UnitedHealthcare pays for services received while
the hearing is pending, if the hearing decision upholds UnitedHealthcare's decision.

5.7 Request for Fair Hearing

UnitedHealthcare affords the member or the representative who filed the appeal on the member's behalf their right to request a fair
hearing through the Kansas Office of Administrative Hearings (OAH) no later than 30 calendar days from the date of the Notice
of Appeal Resolution, unless the appeal is regarding termination, suspension, or reduction of a previously authorized service, if
the member requests continuation of services, within 10 calendar days of the date UnitedHealthcare's mailing of the notice of the
resolution of the appeal.
Members are informed that they may also file for a fair hearing if a Notice of Appeal Resolution is not completed within required
time frames. The Appeals Representative will forward the case file, including the member's written request for hearing, copies of
the entire appeal file with supporting documentation (i.e., pertinent findings and medical records), a copy of the Notice of Appeal
Resolution and other information relevant to the resolution of the appeal including but not limited to, any transcript(s), records, or
written decision(s) from participating providers or delegated entities to the designated OAH. The Appeals Representative will draft
a cover letter for the file that identifies the member's name, identification number, address, telephone number – if applicable, date of
receipt of appeal, summary of actions taken by UnitedHealthcare to resolve the appeal and a summary of the appeal resolution. The file
and cover letter will be sent to the designated OAH no later than 5 calendar days from receipt of the request for said information. The
appropriate representative will prepare and represent UnitedHealthcare at the hearing.

5.8 Processes Related to Reversal of UnitedHealthcare's Initial Decision

If UnitedHealthcare or the Office of Administrative Hearings (OAH) reverses a decision to deny, limit, or delay services that were
not provided while the appeal was pending, UnitedHealthcare will authorize or provide the disputed services promptly, and as
expeditiously as the member's health condition requires. If the decision reverses a decision to deny authorization of services and the
disputed services were received pending appeal, UnitedHealthcare will pay for those services as specified in policy and/or regulation.

15.14 Provider Complaints and Claims Payment Disputes

Provider Complaints

UnitedHealthcare will track and resolve provider complaints within 30 calendar days of receipt. We will respond fully and completely
to your complaints in writing.
To file a complaint, the physician should send their complaint in writing and send it via regular mail to:

UnitedHealthcare
Attention: Formal Complaints and Claim Appeals
PO Box 31364
Salt Lake City, UT 84131-0364

Provider Claims Adjustment Request

If you believe you were underpaid by UnitedHealthcare, you can simplify the submission of requests for claim adjustments and receive
efficient resolution of claim issues by using UHCCommunityPlan.com. Submit a single claim or submit claim batches of 20 or more
claims that are in a paid or denied status directly to UnitedHealthcare for research and reconsideration online.
You may also call Provider Services at 877-542-9235 and select the correct prompts, including opting to speak with a Provider Phone
Representative (PPR). The PPR is trained to address your inquiry and handle initial claim related calls. During the call, if the PPR is
unable to resolve the issue, the PPRs are able to route Providers' issue(s) directly to a Provider Claim Resolution Specialist (PCRS). The
PCRS team is trained to manage more complex and escalated claim service issues.
The PCRS model is designed to make more highly-skilled claims resolution experts available to initiate outbound calls to the Provider
either when Provider expectations are not met or if they need additional information. We may make claim adjustments without requesting
additional information from you. You will see the adjustment on the Provider Remittance Advice. When additional or correct information
is needed, we will ask you to provide it.
The Provider indicates, whether to a PPR, online or via paper request, what action they are expecting from us to close our portion of
the claim in their practice management system.
If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can appeal the determination (see
Formal Claim Appeals).

Provider Formal Claim Appeals

Formal claim appeals are appeals of any payment decisions that DO NOT involve UnitedHealthcare's determination of medical
necessity or obtaining from the physician information pertinent to a determination of medical necessity. Please see the section
addressing the Types of Internal Utilization Management Appeals for a definition of payment decisions involving Utilization
Management appeals. Formal claim appeals may be made for claims that are:

- Denied in entirety
- Denied in part
- Paid at a rate asserted to be inconsistent with contracted rates

Some of the common reasons for formal claim appeals include, but are not limited to, disputes concerning the following reasons:

- Failure to obtain required prior authorization
- Untimely submission
- Reimbursement disputes

All formal claim appeals must be filed within 30 days of the date of the UnitedHealthcare provider remittance.
To file a formal claim appeal, the physician should send a written appeal via regular mail to:

UnitedHealthcare
Attention: Formal Claim Appeals
PO Box 31364
Salt Lake City, UT 84131-0364

The cover letter should state that a formal claim appeal is being made. Several claims with the same reasons for appeal may be combined

in a single appeal letter, with an attached list of claims. State the specific reason for denial as stated on the remittance. UnitedHealthcare
does not accept appeals that fail to address the reason for the denial as stated on the remittance. For appeals of payment rates, state the
basis for the dispute and enclose all relevant documentation, including but not limited to contract rate sheets and fee schedules.
If you are appealing a claim that was denied because filing was not timely, for:
• Electronic claims: include confirmation that UnitedHealthcare or one of its affiliates received and accepted your claim.
• Paper claims: include a copy of a screen print from your accounting software to show the date you submitted the claim.
If you disagree with the outcome of the claim appeal, an arbitration proceeding may be filed.

Provider Requests for State Fair Hearing

If you disagree with the outcome of the appeal review by UnitedHealthcare Community Plan, you can file for a State Fair Hearing. A
Fair Hearing is a formal proceeding before an impartial Hearing Officer, also known as a Presiding Officer, who will listen to the facts
of the case, and then issue a decision based upon the facts and the law.
By statute, a request for a Fair Hearing must be submitted within thirty (30) days of the date of UnitedHealthcare's decision.
Your request for a Fair Hearing would need to be in writing and sent directly to the Office of Administrative Hearings.

Office of Administrative Hearings
1020 S. Kansas Avenue
Topeka, KS 66612
Fax: (785) 296-4848

The Fair Hearing process is coordinated by the Office of Administrative Hearings after it receives notice from the provider that the
provider disagrees with a decision made by UnitedHealthcare. The Office of Administrative Hearings will generally inform the parties that a written decision will be issued within thirty (30) days from the date of the hearing.