

ARIZONA APPEALS INFORMATION PACKET

UNITEDHEALTHCARE OF ARIZONA, INC.

CAREFULLY READ THE INFORMATION IN THIS PACKET AND KEEP IT FOR FUTURE REFERENCE. IT HAS IMPORTANT INFORMATION ABOUT HOW TO APPEAL DECISIONS WE MAKE ABOUT YOUR HEALTH CARE.

Getting Information About the Health Care Appeals Process **Help in Filing an Appeal: Standardized Forms and Consumer Assistance** **from the Department of Insurance and Financial Institutions**

We must send you a copy of this information packet when you first receive your policy, at your request, or the request of your treating provider, and provide access to a copy of this information packet on our website. When your insurance coverage is renewed, we must also send you a separate statement to remind you that you can request another copy of this information packet. Just call our Customer Care at (877) 482-9045 to ask.

At the back of this packet, you will find forms you can use for your appeal. The Arizona Department of Insurance and Financial Institutions (DIFI) ("the Department") developed these forms to help people who want to file a health care appeal. You are not required to use them. We cannot reject your appeal if you do not use them. If you need help in filing an appeal, or you have questions about the appeals process, you may call the Department's Consumer Services Section at (602) 364-2499 or (800) 325-2548 (outside Phoenix), or call us at (877) 482-9045.

How to Know When You Can Appeal

When we do not authorize or approve a service or pay for a claim, we must notify you of your right to appeal that decision. Your notice may come directly from us or through your treating provider.

Decisions You Can Appeal

You can appeal the following decisions:

1. We do not approve a service that you or your treating provider has requested.
2. We do not pay for a service that you have already received.
3. We do not authorize a service or pay a claim because we say that it is not "medically necessary".
4. We do not authorize a service or pay a claim because we or our review agent say that it is not covered under your insurance policy, and you believe it is covered.
5. We do not notify you, within 10 business days of receiving your request, whether or not we will authorize a requested service.
6. We do not authorize a referral to a specialist.

Decisions You Cannot Appeal

You cannot appeal the following decisions:

1. You disagree with our decision as to the amount of "usual and customary charges."
2. You disagree with how we are coordinating benefits when you have health insurance with more than one insurer.
3. You disagree with how we have applied your claims or services to your plan deductible.
4. You disagree with the amount of coinsurance or copayments that you paid.
5. You disagree with our decision to issue or not issue a policy to you.
6. You are dissatisfied with any rate increases you may receive under your insurance policy.
7. You believe we may have violated any other parts of the Arizona Insurance Code.

If you disagree with a decision that is not appealable according to this list, you may still file a complaint with the Arizona Department of Insurance and Financial Institutions, Consumer Services Section, 100 N. 15th Avenue, Suite 261, Phoenix, AZ 85007. You can also file a complaint via their website: www.difi.az.gov.

Who Can File An Appeal?

Either you or your treating provider can file an appeal on your behalf. At the end of this packet is a form that you may use for filing your appeal. You are not required to use this form, and you can send us a letter with the same information. If you decide to appeal our decision to deny authorization of a service, you should tell your treating provider so the provider can help you with the information you need to present your case.

Description of the Appeals Process

There are two types of appeals: an expedited appeal for urgent matters and a standard appeal. Each type of appeal has two (2) levels. The appeals operate in a similar fashion, except that expedited appeals are processed much faster because of the patient's condition.

	Expedited Appeals (for urgently needed services you have not received)	Standard Appeals (for non-urgent services or denied claims)
Level 1 –	Expedited Appeal	Formal Appeal
Level 2 –	Expedited External Independent Review	External Independent Review

We make the decision at Level 1. An outside reviewer, who is completely independent from our company, makes Level 2 decisions. You are not responsible to pay the costs of the external review if you choose to appeal to Level 2.

EXPEDITED APPEAL PROCESS FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED

Level 1 – Expedited Appeal

Your request: If we deny your request for a covered service, you may request an Expedited Appeal. To help your appeal, your provider should also send us any more information (that the provider has not already sent us) to show why you need the requested service.

Our decision: We have 3 business days after we receive the request to make our decision.

If we deny your request: You may immediately appeal to Level 2.

If we grant your request: We will authorize the service and the appeal is over.

If we refer your case to Level 2: We may decide to skip Level 1 and send your case straight to an independent reviewer at Level 2.

Level 2 – Expedited External Independent Review

Your request: You may appeal to Level 2 only after you have appealed through Level 1. You have 5 business days after you receive our Level 1 decision to send us your written request for Expedited External Independent Review. Send your request and any more supporting information to:

UnitedHealthcare Appeals & Grievances
PO Box 6111
Mail Stop CA-0197
Cypress, CA 90630
Phone: (877) 482-9045
Fax: (888) 808-9123

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 2 appeals, depending on the issues in your case:

1. **Medical Necessity**

These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization ("IRO") that is procured by the Arizona Department of Insurance and Financial Institutions, and not connected with our company. The IRO reviewer must be a provider who typically manages the condition under review.

2. **Contract Coverage**

These are cases where we have denied coverage because we believe the requested service is not covered under your insurance policy. For contract coverage cases, the Arizona Department of Insurance and Financial Institutions is the independent reviewer.

Medical Necessity Cases

Within 1 business day of receiving your request, we must:

1. Send a written acknowledgment of the request to the Director of the Department of Insurance and Financial Institutions ("Director"), you, and your treating provider.
2. Send the Director, the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; and the relevant portion of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal level.

Within 2 business days of receiving our information, the Director must send all the submitted information to an external independent reviewer organization (the "IRO").

Within 72 hours of receiving the information, the IRO must make a decision and send the decision to the Director.

Within 1 business day of receiving the IRO's decision, the Director must send a notice of the decision to us you, and your treating provider.

The decision (medical necessity): If the IRO decides that we should provide the service, we must authorize the service. If the IRO agrees with our decision to deny the service, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Cases

Within 1 business day of receiving your request, we must:

1. Send a written acknowledgment of your request to the Director, you, and your treating provider.
2. Send the Director: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues, including a statement of our decision; the criteria used and any clinical reasons for our decision and the relevant portions of our utilization review guidelines.

Within 2 business days of receiving this information, the Director must determine if the service or claim is covered, issue a decision, and send a notice to us, you, and your treating provider.

Referral to the IRO for contract coverage cases: The Director is sometimes unable to determine issues of coverage. If this occurs, the Director will forward your case to an IRO. The IRO will have seventy-two (72) hours to make a decision and send it to the Director. The Director will have 1 business day after receiving the IRO's decision to send the decision to us, you, and your treating provider.

The decision (contract coverage): If you disagree with the Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If we disagree with the Director's final decision, we may also request a hearing before OAH. A hearing must be requested within 30 days of receiving the Director's decision. OAH must promptly schedule and complete a hearing for appeals from expedited Level 2 decisions.

**STANDARD APPEAL PROCESS FOR NON-URGENT
SERVICES AND DENIED CLAIMS**

Level 1 – Formal Appeal

Your request: You may request Formal Appeal if: (1) we deny your request for a covered services, (2) you have an unpaid claim.

You have 2 years from our first denial notice to request Formal Appeal. To help us make a decision on your appeal, you or your provider should also send us any more information (that you have not already sent us) to show why we should authorize the requested service or pay the claim. Send your appeal request and information to:

UnitedHealthcare Appeals & Grievances
PO Box 6111
Mail Stop CA-0197
Cypress, CA 90630

Fax: (888) 404-0949

Our acknowledgment: We have 5 business days after we receive your request for Formal Appeal (“the receipt date”) to send you and your treating provider a notice that we got your request.

Our decision: For a denied service that you have not yet received, we have 30 calendar days after the receipt date to decide whether we should change our decision and authorize your requested service. For denied claims, we have sixty (60) calendar days to decide whether we should change our decision and pay your claim. We will send you and your treating provider our decision in writing. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request: You have four months to appeal to Level 2.

If we grant your request: We will authorize the service or pay the claim and the appeal is over.

If we refer your case to Level 2: We may decide to skip Level 1 and send your case straight to an independent reviewer at Level 2.

Level 2 – External Independent Review

Your request: You may appeal to Level 2 only after you have appealed through Level 1. You have four months after you receive our Level 1 decision to send us your written request for External Independent Review. Send your request and any more supporting information to:

UnitedHealthcare Appeals & Grievances
PO Box 6111
Mail Stop CA-0197
Cypress, CA 90630
Phone: (877) 482-9045
Fax: (888) 404-0949

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 2 appeals, depending on the issues in your case:

A. Medical Necessity

These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for are not medically necessary. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization (“IRO”), procured by the Arizona Department of Insurance and Financial Institutions, and not connected with our company. For medical necessity cases, the reviewer must be a provider who typically manages the condition under review.

Contract Coverage

These are cases where we have denied coverage because we believe the requested service is not covered under your insurance policy. For contract coverage cases, the Arizona Department of Insurance and Financial Institutions is the independent reviewer.

Medical Necessity Cases

Within five (5) business days of receiving your request, we must:

1. Mail a written acknowledgment of the request to the Director, you, and your treating provider.
2. Send the Director: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal level.

Within five (5) days of receiving our information, the Director must send all the submitted information to an external independent review organization ("IRO").

Within twenty-one (21) days of receiving the information, the IRO must make a decision and send the decision to the Director.

Within five (5) business days of receiving the IRO's decision, the Director must send a notice of the decision to us, you, and your treating provider.

The decision (medical necessity): If the IRO decides that we should provide the service or pay the claim, we must authorize the service or pay the claim. If the IRO agrees with our decision to deny the service or payment, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Cases

Within 5 business days of receiving your request, we must:

1. Send a written acknowledgment of your request to the Director, you, and your treating provider.
2. Send the Director: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and any clinical reasons for our decision; and the relevant portion of our utilization review guidelines.

Within 15 business days of receiving this information, the Director must determine if the service or claim is covered, issue a decision, and send a notice to us, you, and your treating provider. If the Director decides that we should recommend the service or pay the claim, we must do so.

Referral to the IRO for Contract Coverage Cases:

The Director is sometimes unable to determine issues of coverage. If this occurs, the Director will forward your case to an IRO. The IRO will have 21 days to make a decision and send it to the Director. The Director will have 5 business days after receiving the IRO's decision to send the decision to us, you, and your treating provider.

The decision (contract coverage): If you disagree with the Director's final decision on a coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If we disagree with the Director's determination of coverage issues, we may also request a hearing before the OAH. Hearings must be requested within 30 calendar days of receiving the coverage issue determination. OAH has rules that govern the conduct of their hearing proceedings.

Obtaining Medical Records

Arizona law (A.R.S. §12-2293) permits you to ask for a copy of your medical records. Your request must be in writing and must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of your records.

Designated Decision Maker: If you have a designated health care decision maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision maker or a person designated in writing by your health care decision maker unless you limit access to your medical records only to yourself or your health care decision maker.

Confidentiality: Medical records disclosed under A.R.S. §12-2293 remain confidential. If you participate in the appeal process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other people.

Documentation for an Appeal

If you decide to file an appeal, you must give us any material justification or documentation for the appeal at the time the appeal is filed. If you gather new information during the course of your appeal, you should give it to us as soon as you get it. You must also give us the address and phone number where you can be contacted. If the appeal is already at Level 2, you should also send the information to the Department.

The Role of the Department of Insurance and Financial Institutions

Arizona law (§A.R.S.20-2533(F)) requires “any member who files a complaint with the Department relating to an adverse decision to pursue the review process prescribed” by law. This means that, for appealable decisions, you must pursue the health care appeals process before the Director can investigate a complaint you may have against our company based on the decision at issue in the appeal.

The appeal process requires the Director to:

1. Oversee the appeals process.
2. Maintain copies of each utilization review plan submitted by insurers.
3. Receive, process, and act on requests from an insurer for External Independent Review.
4. Enforce the decisions of insurers.
5. Review decisions of insurers.
6. Send, when necessary, a record of the proceedings of an appeal to Superior Court or to the Office of Administrative Hearings (OAH).
7. Issue a final administrative decision on coverage issues, including the notice of the right to request a hearing before the OAH.

Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document that is sent by mail is deemed received by the person to whom the document is properly addressed on the fifth business day after mailing. “Properly addressed” means your last known address.