UniCare Health Plan of West Virginia, Inc.
Medicaid Managed Care

March 2019

Practitioner appeal process information

We encourage UniCare Health Plan of West Virginia, Inc. (UniCare) providers and members to seek resolution of issues through our grievances and appeals process. The issues may involve dissatisfaction or concern about another provider, UniCare or a member.

We want to assure providers that they have the right to file an appeal with us for denial, deferral or modification of a claims disposition or postservice request. Providers also have the right to appeal on behalf of a member for denial, deferral or modification of a prior authorization or request for concurrent review. These appeals are treated as member appeals and follow the member appeal process.

Grievances are tracked and trended, resolved within established time frames, and referred to a peer review when needed. The UniCare grievances and appeals process meets all requirements of state and federal law and accreditation agencies. The building blocks of this process are the grievance, grievance appeal and the appeal.

Definitions

An **adverse benefit determination** is any of the following:

- A denial or limited authorization of a requested service, including determinations based on the type, level of service, medical necessity, appropriateness, setting or effectiveness of a covered benefit
- A reduction, suspension or termination of a previously authorized service
- A denial, in whole or in part, of a payment for a service
- Failure to provide services in a timely manner
- Failure to adhere to the required time frames for standard resolution of grievances and appeals
- For a resident of a rural area with only one MCO, the denial of the member's request to obtain services outside the network
- The denial of the member's request to dispute financial liability

A **complaint** is the same as a grievance. It's an expression of dissatisfaction made about UniCare's decision or services received from UniCare when an informal grievance is filed; some complaints may be subject to appeal. If a distinction cannot be made between a grievance and an inquiry, it is considered a grievance.

A **grievance** is an expression of dissatisfaction about any matter other than an adverse benefit determination, either in writing (formally) or orally (informal), to UniCare by a provider or member about any aspect of our or the provider's operation, the provision of health care services, or the activities or behaviors (other than our action) as defined in Chapter 12 of the provider manual (Grievance and Appeals).

A **grievance appeal** is a formal request for UniCare to review a grievance resolution.

An **appeal** is a review by UniCare of an adverse benefit determination.

An **expedited appeal** is an appeal that occurs when taking the time for a standard appeal could seriously jeopardize the member's life; health; or ability to attain, maintain or regain maximum function. Either UniCare or the provider (when the provider is acting on behalf of a member) will determine if an expedited appeal is appropriate.

An **inquiry** is a request for additional information or clarification regarding benefit coverage or how to access medical care/covered benefits. An inquiry is an informational request that is handled at the point of entry or that is forwarded to the appropriate operational area for final response. An inquiry is not an expression of any dissatisfaction.

An **action** is a:

- 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 a payment for a service.
- Failure to provide services in a timely manner, as defined by the state.
- Failure to act within the time frames specified by the state.

Additional information

If a provider or member has a grievance, UniCare would like to hear about the issue either by phone or in writing. Providers and members have the right to file a grievance regarding any aspect of UniCare's services.

- **By phone: 1-800-782-0095** or fax **1-866-387-2968**, Monday to Friday, 8 a.m. to 6 p.m. ET
- **By mail:**
  UniCare Health Plan of West Virginia, Inc.
  Attn: Grievance and Appeals Department
  P.O. Box 91
  Charleston, WV 25321-0091

Please note: UniCare does not discriminate against members or providers for filing a grievance or an appeal. Providers are prohibited from penalizing a member in any way for filing a grievance.

Provider grievances and appeals are classified into the following categories:

- Provider grievances relating to the operation of the plan, including:
  - Benefit interpretation
  - Claim processing
  - Reimbursement
- Provider appeals related to actions

Member grievances, grievance appeals and appeals include but are not limited to the following:

- Access to health care services
- Care and treatment by a provider
- Issues having to do with how we conduct business

Please note: UniCare offers members an expedited appeals process for decisions involving urgently needed care. Both standard and expedited appeals are reviewed by a person who is not subordinate to the initial decision-maker.