

SERFF Tracking Number: UHLC-128051259 State: Arkansas
Filing Company: UnitedHealthcare Insurance Company of the River Valley State Tracking Number:
Company Tracking Number: APPEALSAMD.I.AR.RV
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: APPEALSAMD.I.AR.RV
Project Name/Number: APPEALSAMD.I.AR.RV/APPEALSAMD.I.AR.RV

Filing at a Glance

Company: UnitedHealthcare Insurance Company of the River Valley

Product Name: APPEALSAMD.I.AR.RV SERFF Tr Num: UHLC-128051259 State: Arkansas

TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved- State Tr Num:
Closed

Sub-TOI: H16G.001A Any Size Group - PPO Co Tr Num: APPEALSAMD.I.AR.RV State Status: Approved-Closed

Filing Type: Form

Author: Kelly Smith

Reviewer(s): Rosalind Minor

Date Submitted: 01/31/2012

Disposition Date: 02/01/2012

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: APPEALSAMD.I.AR.RV

Status of Filing in Domicile: Not Filed

Project Number: APPEALSAMD.I.AR.RV

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Employer

Overall Rate Impact:

Filing Status Changed: 02/01/2012

Deemer Date:

State Status Changed: 02/01/2012

Submitted By: Kelly Smith

Created By: Kelly Smith

Corresponding Filing Tracking Number: APPEALSAMD.I.AR.RV

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

Member Complaint, Appeal, and Dispute Resolution Procedures Amendment: APPEALSAMD.I.AR.RV

Company and Contact

Filing Contact Information

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Kelly Smith, Manager RGA Kelly_Smith@uhc.com
 800 King Farm Blvd. 240-632-8061 [Phone]
 Suite 500
 Rockville, MD 20850

Filing Company Information

UnitedHealthcare Insurance Company of the CoCode: 12231 State of Domicile: Illinois
 River Valley
 1300 River Drive, Suite 200 Group Code: 707 Company Type: Health
 Moline, IL 61265 Group Name: State ID Number:
 (309) 765-1485 ext. [Phone] FEIN Number: 20-1902768

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare Insurance Company of the River Valley	\$50.00	01/31/2012	55953641

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/01/2012	02/01/2012

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	APPEALSAMD.I.AR.RV	Kelly Smith	01/31/2012	01/31/2012

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Disposition

Disposition Date: 02/01/2012

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Cover Letter APPEALSAMD.I.AR.RV	Approved-Closed	Yes
Form (revised)	APPEALSAMD.I.AR.RV	Approved-Closed	Yes
Form	APPEALSAMD.I.AR.RV	Replaced	Yes

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Amendment Letter

Submitted Date: 01/31/2012

Comments:

Minor correction to form number.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
APPEALSA MD.I.AR.RV	Policy/Contr act/Fraternal	APPEALSA MD.I.AR.RV	Initial				46.600	APPEALSAM D.I.AR.RV.pdf
	Certificate: Amendment, Insert Page, Endorsemen t or Rider							

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Form Schedule

Lead Form Number: APPEALSAMD.I.AR.RV

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/01/2012	V	APPEALSAMD.I.AR.RV	Policy/Contract/Fraternal	Initial		46.600	APPEALSAMD.I.AR.RV.pdf
			al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider				

UnitedHealthcare Insurance Company of the River Valley

**MEMBER COMPLAINT, APPEAL, AND DISPUTE RESOLUTION
AMENDMENT TO
FORM NUMBER UHC ARKANSAS PPO COC 08-09**

ARTICLE 17– MEMBER COMPLAINT, APPEAL, AND DISPUTE RESOLUTION PROCEDURES *is amended by replacing the language in Article 17 with the following:*

ARTICLE 17 - MEMBER COMPLAINT, APPEAL, AND DISPUTE RESOLUTION PROCEDURES

- 17.1 This Article sets forth a formal system for resolving Complaints and Appeals by Members concerning coverage determinations, the provision of health care services or other matters concerning the operation of UnitedHealthcare.
- 17.2 The following definitions apply to this Article 17:
- 17.2.1 “Appeal” means a Complaint, which having been reported to UnitedHealthcare by the Member and remaining unresolved to the Member’s satisfaction, is filed for formal proceedings as set forth in this Article 17.
- 17.2.2 “Authorized Representative” means the Member’s guardian or an individual the Member has authorized to act on his or her behalf, including but not limited to the Member’s Physician.
- 17.2.3 “Clinical Peer” means a health care professional who is in the same profession and same or similar specialty as the health care Provider who typically manages the medical condition, procedures or treatment under review.
- 17.2.4 “Complaint” means an oral or written expression of dissatisfaction relating to the policies of or the services provided by UnitedHealthcare.
- 17.2.5 “Post-Service Claim” means any claim for a benefit that is not a Pre-Service Claim.
- 17.2.6 “Pre-Service Claim” means any claim for a benefit with respect to which the terms of the Contract condition receipt of the benefit, in whole or part, based on approval of the benefit in advance of obtaining medical care
- 17.2.7 “Urgent Care Claim” means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations (a) could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function; or (b) in the opinion of a Physician with knowledge of the Member’s medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- 17.3 Most Complaints can be resolved satisfactorily on an informal basis by consultation between the Member, UnitedHealthcare staff, and/or the health care practitioner from whom the Member has received services. If a Member’s Complaint is not resolved through informal consultation, the Member or Member’s Authorized Representative may request a formal Appeal. If the Member wants to designate an Authorized Representative to assist him or her with the Appeal, this must be done in writing. A Member’s Authorized Representative may not file a formal Appeal without explicit, written designation by the Member.

17.4 **Expedited Appeal Procedure for Urgent Care Claims.** For Urgent Care Claims, the Member or Member's Authorized Representative may contact UnitedHealthcare, orally or in writing, to request expedited consideration of the Member's formal Appeal.

17.4.1 In determining whether a claim is for urgent care, we will apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If the request for expedited consideration is denied by UnitedHealthcare, the Appeal will automatically be reviewed by UnitedHealthcare according to the Appeal Procedure of section 17.5. The request for expedited consideration will not be denied if a Physician with knowledge of the Member's medical condition determines that a claim involves urgent care.

17.4.2 We will submit the expedited Appeal to an independent Physician reviewer. The independent Physician reviewer will be a Clinical Peer, who has no material, professional, familial or financial affiliation with UnitedHealthcare or the Member, or material, familial or financial connection to the case and/or outcome.

17.4.3 Within 72 hours after we have received a request for expedited handling which includes all necessary information, we will issue a decision based on the independent Physician reviewer's final determination to the Member or Member's Authorized Representative by telephone or facsimile. If additional information is needed, the Member or Member's Authorized Representative will be notified within 24 hours of receipt of the expedited Appeal request specifying what information is needed to make a decision. When the additional information is received, a final decision will be made within 48 hours of receipt of the specified information or at the end of the period given to provide the specified information, whichever is earlier.

17.4.4 If UnitedHealthcare's final decision is adverse to the Member, the Member or Member's Authorized Representative may request binding arbitration as provided in section 17.10.

17.5 **Appeal Procedure for Pre-Service and Post-Service Claims that are not Urgent Care Claims.** For Pre-Service and Post-Service Claims that are not Urgent Care Claims, the Member or his or her designee, guardian, or Attending Physician may request an Appeal by completing a written "Appeal Form."

17.5.1 The Appeal Form shall be provided by UnitedHealthcare upon the written or oral request of the Member or Member's Authorized Representative. The Appeal Form must be completed and filed to UnitedHealthcare within 180 calendar days from the date (a) the Member received notification of a denial of coverage or (b) the problem in question occurred. The Appeal Form shall be completed and signed and the facts as alleged shall be binding on the Member. The Appeal Form shall be filed by mail, facsimile, or hand-delivery to UnitedHealthcare, in accordance with the instructions provided with the Appeal Form.

17.5.2 We shall issue a decision in writing to the Member or Member's Authorized Representative within the following timeframes:

17.5.2.1 Pre-Service Claim: 15 calendar days after receipt of the Appeal Form.

17.5.2.2 Post-Service Claim: 30 calendar days after receipt of the Appeal Form.

If the Member or Member's Authorized Representative is not satisfied with the decision described in this section, the Member or Member's Authorized Representative may request an External Review as provided in section 17.6.

17.6 **Federal External Review Program**

If, after exhausting your internal appeals, you are not satisfied with the determination made by us, or if we fail to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of our determination.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons
- The exclusions for Experimental or Investigational Services or Unproven Services.
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received our decision.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an *Independent Review Organization (IRO)*. We have entered into agreements with three or more *IROs* that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

17.7 **Standard External Review**

A standard external review is comprised of all of the following:

- A preliminary review by us of the request.
- A referral of the request by us to the *IRO*.
- A decision by the *IRO*.

Within the applicable timeframe after receipt of the request, we will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Policy at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that we may process the request.

After we complete the preliminary review, we will issue a notification in writing to you. If the request is eligible for external review, we will assign an *IRO* to conduct such review. We will

assign requests by either rotating claims assignments among the *IROs* or by using a random selection process.

The *IRO* will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the *IRO* within ten business days following the date of receipt of the notice additional information that the *IRO* will consider when conducting the external review. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.

We will provide to the assigned *IRO* the documents and information considered in making our determination. The documents include:

- All relevant medical records.
- All other documents relied upon by us.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and we will include it with the documents forwarded to the *IRO*.

In reaching a decision, the *IRO* will review the claim anew and not be bound by any decisions or conclusions reached by us. The *IRO* will provide written notice of its determination (the "*Final External Review Decision*") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The *IRO* will deliver the notice of *Final External Review Decision* to you and us, and it will include the clinical basis for the determination.

Upon receipt of a *Final External Review Decision* reversing our determination, we will immediately provide coverage or payment for the Benefit claim at issue in accordance with the terms and conditions of the Policy, and any applicable law regarding plan remedies. If the *Final External Review Decision* is that payment or referral will not be made, we will not be obligated to provide Benefits for the health care service or procedure.

17.8 Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, we will determine whether the individual meets both of the following:

- Is or was covered under the Policy at the time the health care service or procedure that is at issue in the request was provided.

- Has provided all the information and forms required so that we may process the request.

After we complete the review, we will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, we will assign an *IRO* in the same manner we utilize to assign standard external reviews to *IROs*. We will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned *IRO* electronically or by telephone or facsimile or any other available expeditious method. The *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the *IRO* will review the claim anew and not be bound by any decisions or conclusions reached by us. The *IRO* will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the *IRO* receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned *IRO* will provide written confirmation of the decision to you and to us.

You may contact us at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

[Effective Date of this Amendment: _____]

(Name and Title)

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Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	02/01/2012
Bypass Reason:	Flesch Score - 46.6 Application - N/A PPACA - N/A		

Comments:

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	02/01/2012
Bypass Reason:	Flesch Score - 46.6 Application - N/A PPACA - N/A		

Comments:

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	02/01/2012
Bypass Reason:	Flesch Score - 46.6 Application - N/A PPACA - N/A		

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter APPEALSAMD.I.AR.RV	Approved-Closed	02/01/2012

Comments:

Attachment:

APPEALSAMD.I.AR.RV Cover Letter.pdf



January 30, 2012

Ms. Rosalyn Minor
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, Arkansas 72201

Re: UnitedHealthcare Insurance Company of the River Valley
NAIC No. 12231

Member Complaint, Appeal, and Dispute Resolution Procedures Amendment

Amendment: APPEALSAMD.I.AR.RV

Flesch Score: 46.6

Dear Ms. Minor,

On behalf of UnitedHealthcare Insurance Company of the River Valley, I am submitting the amendment listed below for small and large groups. The appeals language has been modified to comply with federal legislation.

Form Number
APPEALSAMD.I.AR.RV

Please note that issuance instructions that appear in shaded italic text are deleted prior to issuance to the member. The members will receive amendments that are in black text, without brackets or issuance instructions.

If you have any questions regarding this submission, please feel free to call me at the number shown below. Thank you.

Information contained within this form may also be used in an online format with appropriate changes in font, format and design to more easily accommodate online viewing or issuance. We want to assure the Department that education will be provided to the brokers, employer groups and the employees regarding access and alternatives to electronic issuance.

If you have any questions or concerns regarding this submission, please feel free to call me at the number shown below.

Sincerely,

Kelly Smith
Manager, Regulatory Affairs

kelly_smith@uhc.com
Phone: 240-632-8061

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Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/31/2012	Form	APPEALSAMD.I.AR.RV	01/31/2012	APPEALSAMD.I.AR.RV.pdf (Superseded)

UnitedHealthcare Insurance Company of the River Valley

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An external review request should include all of the following:

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- The Covered Person's name, address, and insurance ID number.
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- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

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- An expedited external review.

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- Has provided all the information and forms required so that we may process the request.

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assign requests by either rotating claims assignments among the *IROs* or by using a random selection process.

The *IRO* will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the *IRO* within ten business days following the date of receipt of the notice additional information that the *IRO* will consider when conducting the external review. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.

We will provide to the assigned *IRO* the documents and information considered in making our determination. The documents include:

- All relevant medical records.
- All other documents relied upon by us.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and we will include it with the documents forwarded to the *IRO*.

In reaching a decision, the *IRO* will review the claim anew and not be bound by any decisions or conclusions reached by us. The *IRO* will provide written notice of its determination (the "*Final External Review Decision*") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The *IRO* will deliver the notice of *Final External Review Decision* to you and us, and it will include the clinical basis for the determination.

Upon receipt of a *Final External Review Decision* reversing our determination, we will immediately provide coverage or payment for the Benefit claim at issue in accordance with the terms and conditions of the Policy, and any applicable law regarding plan remedies. If the *Final External Review Decision* is that payment or referral will not be made, we will not be obligated to provide Benefits for the health care service or procedure.

17.8 Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, we will determine whether the individual meets both of the following:

- Is or was covered under the Policy at the time the health care service or procedure that is at issue in the request was provided.

- Has provided all the information and forms required so that we may process the request.

After we complete the review, we will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, we will assign an *IRO* in the same manner we utilize to assign standard external reviews to *IROs*. We will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned *IRO* electronically or by telephone or facsimile or any other available expeditious method. The *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the *IRO* will review the claim anew and not be bound by any decisions or conclusions reached by us. The *IRO* will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the *IRO* receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned *IRO* will provide written confirmation of the decision to you and to us.

You may contact us at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

[Effective Date of this Amendment: _____]

(Name and Title)