Adverse Benefit Determination (ABD)

An adverse benefit determination refers to when your Medicaid managed care organization ("MCO" also called "plan") does one of the following:

- denies, reduces, suspends, terminates or delays a previously authorized service;
- denies or limits authorization of a requested service determination (e.g. 2 hours of speech therapy/week for 6 months were prescribed and plan approved 1 hour/week for one month);
- fails to provide service in a timely manner;
- fails to act within required timeframes for resolution of grievance or appeal; and
- denies in whole or in part the payment for a service.

In addition, ABDs include the denial of an enrollee's request for an out-of-network service if the enrollee lives in a rural area and there is only one MCO.

What notice requirements apply when an Adverse Benefit Determination (ADB) is made?

The ABD notice must be in writing and must include the following information:

- the ABD that has been made;
- reason(s) for the ABD (including the right to copies of all documents relevant to the decision free of charge);
- right to request an appeal, including:
    - information on exhausting one level of appeal
    - right to request a state fair hearing;
- process for appeal;
- circumstances for an expedited appeal and how to request;
- right to have benefits continue pending resolution of the appeal, including:
    - how to request continued benefits

- circumstances under which enrollee may be required to repay the costs of those services.

Additionally, the notice must be accessible to individuals with disabilities or limited English proficiency. A sample ABD notice is attached.

What time standards apply to various ABD notices and decisions?

- If the action concerns a termination, suspension, or reduction of a benefit written, notice must be sent 10 days before the date of action.
- If the action concerns a denial of payment, notice must be sent at time of the action-affecting claim.
- If the action concerns a standard service authorization decision that denies or limits services, notice must be sent within 14 days.
- If an expedited service authorization has been requested, a decision must be made and notice must be sent within 72 hours.

What happens if you disagree with the ABD notice?

First you must file an appeal with your MCO. This is called "exhaustion." Exhaustion requires that enrollees must first go through the MCO's appeal process before she/ he can request a fair hearing from the state Medicaid Agency (AHCA). In other words, a fair hearing can only be requested ***after*** the MCO decides not to change their adverse benefit determination.

Are there any exceptions to the exhaustion requirement?

Yes. If the MCO does not follow the notice and timing requirements in federal Medicaid regulations (examples are below), the enrollee is "deemed to have exhausted" the MCO appeal process and can request a state fair hearing.

The following are examples of when exhaustion should be "deemed" to have occurred and the enrollee can request a fair hearing from AHCA:

- Enrollee speaks Spanish and notice was only in English;
- Notice did not clearly explain the right to continued benefits;
- Notice was not sent within 10 days of a termination, suspension or reduction of previously authorized benefits.

UnitedHealthcare®
Community Plan

3100 SW 145th Avenue, Suite 200
Miramar, FL 33027

B_rc

PLAN ID:

NOTICE OF ADVERSE BENEFIT DETERMINATION

Dear :

UnitedHealthcare Community Plan has reviewed your request for Homemaker Services 42 hours a week, which we received on (date) After our review, this service has been:

DENIED as of (date)

We made our decision because:
(Check all boxes that apply)

☒ We determined that your requested services are **not medically necessary** because the services do not meet either of the reason(s) checked below: *(See Rule)*

- ☐ Meet all of the criteria as defined in Rule 59G-1.010(166), F.A.C., for all nursing facility services and mixed services; OR
- ☒ Meet all of the following criteria for all extended state plan services used for the purposes of maintenance therapy and all other home and community-based services:

1. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
2. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
3. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider;

and one of the following:

1. Enable the enrollee to maintain or regain functional capacity; or
2. Enable an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

☐ The requested **service is not a covered benefit**.

☐ **Other authority**

The facts that we used to make our decision are: Your assessment tells us that you need some help with cleaning your home, chores and making meals.

You are getting 14 hours a week of personal care to help you.
The direct service worker can clean the bedroom and bathroom after helping you with your personal care.

You live with family who helps you. Your family also uses areas of the home. You live with your direct service worker.

In my clinical opinion, needs are being met by your current services and supports. These hours can be split to meet your needs during the day.

You, or someone legally authorized to do so, can ask us for a complete copy of your file, including medical records, a copy of plan review criteria and guidelines, contract provisions, other documents, records, and other information relevant to the adverse benefit determination. These will be provided free of charge.

You may request these documents by contacting: 1-800-791-9233.

Right to Request a Plan Appeal

If you do not agree with this decision, you have the right to request a plan appeal from UnitedHealthcare Community Plan. When you ask for a plan appeal, UnitedHealthcare Community Plan has a different health care professional review the decision that was made.

How to Ask for a Plan Appeal:

You can ask for a plan appeal in writing or by calling us. Your case manager can help you with this, if you have one. We must receive the request *within 60 days* of the date of this letter. (If you wish to continue your services until a final decision is made on your appeal, we must receive your request sooner. See the "How to Ask for your Services to Continue" section below for details.) Here is where to call or send your request:

UnitedHealthcare
Attention: Appeals and Grievances
P.O. Box 31364
Salt Lake City, UT 84131
1-800-791-9233 (toll-free), or 711 (TTY)
1-800-757-2617 (fax)

Your written request for a plan appeal must include the following information:

- Your name
- Your member number
- Your Medicaid ID number
- A phone number where we can reach you or your legal representative

You may also include the following information if you have it:

- Why you think we should change the decision
- Any medical information to support the request
- Who you would like to help with your plan appeal

Within five days of getting your plan appeal request, we will tell you in writing that we got your plan appeal request unless you ask for an expedited (fast) plan appeal. We will give you an answer to your plan appeal within 30 days of you asking for a plan appeal.

How to Ask for an Expedited (Fast) Plan Appeal if Your Health is At Risk:

You can ask for an "expedited plan appeal" if you think that waiting 30 days for a plan appeal decision resolution could put your life, health, or your ability to attain, maintain, or regain maximum function in danger. You can call or write us (see above), but you need to make sure that you ask us to *expedite* the plan appeal. We may not agree that your plan appeal needs to be expedited, but you will be told of this decision. We will still process your plan appeal under normal time frames. If we do need to expedite your plan appeal, you will get our plan appeal resolution within 48 hours after we receive your plan appeal request. This is true whether you asked for the plan appeal by phone or in writing.

How to Ask for your Services to Continue:

If you are now getting the service that is scheduled to be reduced, suspended or terminated, you have the right to keep getting those services until a final decision is made in a plan appeal and, if requested, fair hearing. If your services are continued, there will be no change in your services until a final decision is made in your plan appeal and, if requested, fair hearing.

If your services are continued and our decision is upheld in a plan appeal or fair hearing, we may ask that you pay for the cost of those services. We will not take away your Medicaid benefits. We cannot ask your family or legal representative to pay for the services.

To have your services continue during the plan appeal, you MUST file your plan appeal AND ask to continue your services within this time frame:

File a request for your services to continue with UnitedHealthcare Community Plan no later than 10 days after this letter was mailed OR on or before the first day that your services are scheduled to be reduced, suspended, or terminated, whichever is later. You can ask for a plan appeal by phone. If you do this, you must then ***also*** make a request in writing. **Be sure to tell us if you want your services to continue.**

To have your services continue during the fair hearing, you MUST file your fair hearing request AND ask for continued services within this time frame:

If you were receiving services during your plan appeal, you can file the request for your services to continue with the Agency for Health Care Administration (Agency) **no later than 10 days** from the date on your notice of plan appeal resolution OR on or before the first day that your services are scheduled to be reduced, suspended, or terminated, ***whichever is later***.

What to Do if You Disagree with the Appeal Decision

The plan appeal process will result in a timely notice of plan appeal resolution (notice) that outlines the outcome of the plan appeal. If you still do not agree after you receive our notice, or if you do not receive the notice timely, you can ask for a fair hearing.

How to Ask for a Fair Hearing:

When you ask for a Medicaid fair hearing, a hearing officer who works for the state reviews the decision that was made. You may ask for a fair hearing any time up to 120 days after you get our notice of plan appeal resolution. **You must finish your appeal process first.**

You may ask for a fair hearing by calling or writing to:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906

(877) 254-1055 *(toll-free)*
239-338-2642 *(fax)*
MedicaidHearingUnit@ahca.myflorida.com

After getting your fair hearing request, the Agency will tell you in writing that they got your fair hearing request.

If you have questions, call us at 1-800-791-9233 or TTY **711**. For more information on your rights, review the Grievance and Appeal section in your Member Handbook. It can be found online at: www.uhccommunityplan.com.

Sincerely,

Long term Care Medical Director
UnitedHealthcare Community Plan

CC: <Requesting Provider>
<Fax: >

UnitedHealthcare
Community Plan

UnitedHealthcare Community Plan does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call Member Services at **1-800-791-9233, TTY 711**, Monday through Friday, 8:00 a.m. to 7:00 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html

Phone:
Toll-free **1-800-368-1019, 1-800-537-7697** (TDD)

Mail:
U.S. Dept. of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201

If you need help with your complaint, please call the toll-free member phone number listed on your member ID card.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call Member Services at **1-800-791-9233, TTY 711**, Monday through Friday, 8:00 a.m. to 7:00 p.m.

UnitedHealthcare
Community Plan

UnitedHealthcare Community Plan no da un tratamiento diferente a sus miembros en base a su sexo, edad, raza, color, discapacidad u origen nacional.

Si usted piensa que ha sido tratado injustamente por razones como su sexo, edad, raza, color, discapacidad u origen nacional, puede enviar una queja a:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

Usted tiene que enviar la queja dentro de los 60 días de la fecha cuando se enteró de ella. Se le enviará la decisión en un plazo de 30 días. Si no está de acuerdo con la decisión, tiene 15 días para solicitar que la consideremos de nuevo.

Si usted necesita ayuda con su queja, por favor llame a Servicios para Miembros al **1-800-791-9233, TTY 711**, de lunes a viernes, de 8:00 a.m. a 7:00 p.m.

Usted también puede presentar una queja con el Departamento de Salud y Servicios Humanos de los Estados Unidos.

Internet:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Formas para las quejas se encuentran disponibles en:
http://www.hhs.gov/ocr/office/file/index.html

Teléfono:
Llamada gratuita, **1-800-368-1019, 1-800-537-7697** (TDD)

Correo:
U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201

Si necesita ayuda para presentar su queja, por favor llame al número gratuito para miembros anotado en su tarjeta de identificación como miembro.

Ofrecemos servicios gratuitos para ayudarle a comunicarse con nosotros. Tales como, cartas en otros idiomas o en letra grande. O bien, puede solicitar un intérprete. Para pedir ayuda, llame a Servicios para Miembros al **1-800-791-9233, TTY 711**, de lunes a viernes, de 8:00 a.m. a 7:00 p.m.

ATTENTION: If you do not speak English, language assistance services, at no cost to you, are available. Call **1- 800-791-9233, TTY 711**.

ATENCIÓN: Si no habla inglés, los servicios de asistencia de idiomas están disponibles sin costo para usted. Llame al **1- 800-791-9233, TTY 711**.

ATANSYON: Si w pa pale Anglè, gen sèvis èd pou lang ki disponib san w pa peye anyen. Rele **1- 800-791-9233, TTY 711**.

ВНИМАНИЕ: Если Вы не говорите по-русски, Вы можете воспользоваться бесплатной языковой помощью. Позвоните по телефону **1- 800-791-9233, телетайп 711**.

ATENÇÃO: Se não fala inglês, estão disponíveis serviços de assistência linguística sem nenhum custo para si. Ligue para o **1- 800-791-9233, TTY 711**.

注意：如果您不會說英文，您可獲得免費語言協助服務。請致電 **1- 800-791-9233，聽障專線 (TTY) 711**。