SECTION 7: GRIEVANCES AND APPEALS

WHAT TO DO IF YOU RECEIVE A:

- Pre-service or prior authorization denial for lack of information – Resubmit the request to UM with the UM requested additional information
- Pre-service or prior authorization denial for lack of medical necessity, failure to meet criteria, or non-benefit – Appeal on behalf of the member by contacting the Molina Healthcare Member Services Department at (888) 665-4621
- Post-service or retrospective authorization denial – Appeal on behalf of the member by contacting the Molina Healthcare Member Services Department at (888) 665-4621
- Payment denial for any reason except for an unclean claim – Appeal your payment denial within three hundred sixty five (365) days using the dispute resolution process
- Non-payment for an unclean claims – Submit a clean claim within the noted timeframe and with the information that is requested in the remit message

GRIEVANCES AND APPEALS

This section addresses the identification, review, and resolution process for four (4) distinct topics:

- Provider/Practitioner Appeal (related to an authorization determination)
- Provider Disputes-Title 28, CCR, Section 1300,71.38 (related to provider claims appeals)
- Member Appeals (related to an authorization determination)
- Member Grievance (related to a Potential Quality of Care (PQOC) issue)

More information regarding PQOCs may be obtained by contacting Molina Healthcare's Quality Improvement Department at (800) 526-8196 ext. 126137.

PROVIDER/PRACTITIONER GRIEVANCES OR COMPLAINTS - THE "APPEALS PROCESS"

A Provider/Practitioner grievance or complaint is described in Title 22, California Code of Regulations (CCR), as a written entry into the appeals process. Molina Healthcare maintains two types of appeals:

- Appeals regarding non-payment or processing of claims known as Provider Disputes.

A Provider/Practitioner of medical services may submit to Molina Healthcare an appeal concerning the modification or denial of a requested service or the payment processing or non-payment of a claim by the Plan. Molina Healthcare will comply with the requirements specified in Section 56262, of Title 22 of the CCR, and Title 28, CCR, Section 1300.71 and 1300.38 Claims Settlement Practices and Provider Dispute Resolution.

- Appeals regarding modifications or denial of a service request.

The Provider/Practitioner Appeal Process offers recourse for Providers/Practitioners who are dissatisfied with a denial or decision from Molina Healthcare. There are two (2) types of appeals-Provider Disputes and appeals for prior authorization denied.

The initial appeal is considered to be a First Level appeal, and if the disputed denial is upheld during the First Level appeal, a final or Second Level appeal may be requested.

PROVIDER DISPUTES

A Provider Dispute is defined as a written notice prepared by a provider that:

- Challenges, appeals, or requests reconsideration of a claim that has been denied, adjusted, or contested
- Challenges Molina Healthcare's request for reimbursement for an overpayment of a claim
- Seeks resolution of a billing determination or other contractual dispute

For claims with dates of service in 2004 or after, all provider disputes require the submission of a Provider Dispute Resolution Request Form or a Letter of Explanation, which serves as a written first level appeal by the provider. For paper submission, Molina Healthcare will acknowledge the receipt of the dispute within fifteen (15) working days and within two (2) days for electronic submissions. If additional information is needed from the provider, Molina Healthcare has forty five (45) working days to request necessary additional information. Once notified in writing, the provider has thirty (30) working days to submit additional information or the claim dispute will be closed by Molina Healthcare.

Providers may initiate a first level appeal by submitting and completing a Provider Dispute Resolution Request Form within three hundred sixty five (365) days from the last date of action on the issue. The written dispute form must include the provider name, identification number, contact information, date of service, claim number, and explanation for the dispute. In addition, the following documentation is required to review and process a claims appeal:

- Provider Dispute Resolution Request Form or a Letter of Explanation
- A copy of the original claim(s)
- A copy of the disposition of the original claim(s) in the form of the Explanation of Benefit
- Documented reason for appeal
- A copy of the medical record/progress notes to support the appeal, when applicable

Provider Disputes and supporting documentation (via paper) should be submitted to:

Molina Healthcare of California
P.O. Box 22722
Long Beach, CA 90801
Attn : Provider Grievance and Appeals Unit

Appeals Involving Shared Risk Capitated IPAs/Medical Groups

If an appeal involves a member who is assigned to a Primary Care Practitioner (PCP) or IPA/Medical Group under a shared-risk capitated compensation agreement, Molina Healthcare will delegate the first level of appeal to the IPA/Medical Group. Molina Healthcare does not delegate the second level appeals heard by the Health plan. However, Molina Healthcare will make the final determination on all appeals received from Providers/Practitioners. All first appeals should be mailed directly to the participating IPA/Medical Group. All first appeals received by Molina Healthcare will be forwarded to the IPA/Medical Group upon receipt. The IPA/Medical Group will review the appeal and make an initial determination within fifteen (15) days of receipt of the appeal.

If the decision is to overturn the original denial, the IPA/Medical Group will respond to the Provider/Practitioner and pay the claim. If the determination is to continue to uphold the denial, the IPA/Medical Group will then forward the first level appeal to Molina Healthcare or its affiliated health plan (Attention: Utilization Management Department) for a second level appeal determination. If Molina Healthcare upholds the denial, the Provider/Practitioner will be notified of the second level appeal decision at that time.

Appeals Involving Direct Providers/Practitioners

If an appeal involves services that were provided to a member who is assigned to a Direct PCP, Molina Healthcare will administer the Provider/Practitioner appeals process.

Appeals Address

Claims for plan or shared-risk services must be submitted to:

Molina Healthcare of California
P.O. Box 22722
Long Beach, CA 90801
Attn : Provider Grievance and Appeals Unit

Balance Billing

Molina Healthcare prohibits Providers/Practitioners from balance-billing a member when the denial disputed in a First Level or Second Level appeal is upheld. The Provider/Practitioner is expected to adjust off the balance owed if the denial is upheld in the appeals process.

For more detailed information regarding Claims Submissions and Provider Disputes see "Claims" Section 22 in this manual.

MEMBER APPEALS

A Provider/Practitioner on behalf of a member may appeal a Utilization Management decision to deny or modify a requested service.

Member Appeals Process

If the Member or Provider/Practitioner on behalf of a member is dissatisfied with an adverse authorization decision, he or she may initiate an appeal by telephone, fax, in writing, or on Molina Healthcare's website. Providers/Practitioners may refer members to Molina Healthcare's website for additional information on how to file a member grievance. Contact the department noted below, Monday-Friday between 7:00 am and 7:00 pm:

Molina Healthcare of California
Attn: Member Grievance and Appeals Unit
200 Oceangate, Suite 100
Long Beach, CA 90802
1 (888) 665-4621
Fax: (562) 901-9632
www.molinahealthcare.com

Standard (30-day) and Expedited (72-hour) Appeal Processes

Health plans have thirty (30) days to process a standard appeal. In some cases, members have the right to an expedited, seventy two (72) hour appeal. Members can get a faster, expedited appeal if the member's health or ability to function could be seriously harmed by waiting for a standard appeal. If a member requests an expedited appeal, the health plan will evaluate the member's request and medical condition to determine if the appeal qualifies as an expedited, seventy two (72) hour appeal. If not, the appeal will be processed within the standard thirty (30) days.

(The following sections indicated with an asterisk were extracted verbatim from the Medi-Cal Program Evidence of Coverage Guide for Providers/Practitioners to understand Independent Medical Review as explained to the members)

*Independent Medical Review

You may request an independent medical review ("IMR") of a disputed healthcare service from the Department of Managed Health Care (DMHC) if you believe that healthcare services have been improperly denied, modified, or delayed by Molina Healthcare or one of its contracted providers. A "disputed healthcare service" is any healthcare service eligible for coverage and payment that has been denied, modified, or delayed by Molina Healthcare or one of its contracted providers, in whole or in part because the service is not medically necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for an IMR. Molina Healthcare will provide you with an IMR application form with any disposition letter that denies, modifies, or delays healthcare services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against Molina Healthcare regarding the disputed health care service.

Eligibility: Your application for an IMR will be reviewed by the DMHC to confirm that:

1. A. Your provider has recommended a healthcare service as medically necessary, or

   B. You have received urgent care or emergency services that a provider determined was medically necessary, or

   C. You have been seen by a Plan Provider for the diagnosis or treatment of the medical condition for which you seek medical review;

2. The disputed healthcare service has been denied, modified, or delayed by Molina Healthcare or one of its contracting providers, based in whole or in part on a decision that the healthcare service is not medically necessary: and

3. You have filed a grievance with Molina Healthcare or its contracting provider and the disputed decision is upheld or the grievance remains unresolved after 30 days. If your grievance requires expedited review you may bring it immediately to the DMHC's attention. The DMHC may waive the requirement that you follow Molina Healthcare's grievance process in extraordinary and compelling cases.

If your case is eligible for IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the care is medically necessary. You will get a copy of the assessment made in your case. If the IMR determines the service is medically necessary, Molina Healthcare will provide the healthcare service.

For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within thirty (30) days of receipt of your application and supporting documents. For urgent cases involving an imminent and serious threat to your health, including but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health, the IMR organization must provide its determination within three (3) business days.

For more information regarding the IMR process, or to request an application form, please call Molina Healthcare at 1 (888) 665-4621. If you are hearing impaired, call our dedicated TTY line at 1 (800) 479-3310.

*Expedited State Fair Hearing

You or your provider may request an Expedited State Hearing by calling, writing or faxing Department of Health Care Services, Expedited Hearing Unit, 744 P Street, MS 1965, Sacramento, CA 95814, Fax: 1 (916) 229-4267. Molina Healthcare or your provider must indicate that taking the time for a standard resolution could seriously jeopardize your life or health or ability to attain, maintain or regain maximum function. When Expedited Hearing Unit determines that your appeal satisfies the expedited criteria and when all necessary clinical information has been received by the Unit, the expedited hearing will be scheduled. If the criteria are not met, it will be scheduled for a routine State Fair Hearing as described above.

*Department of Managed Healthcare Services (DMHC) Assistance

The California Department of Managed Health Care is responsible for regulating health care services plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-888- 665-4621, and use your health plan's grievance before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than thirty (30) days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of

medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll free telephone number (1-888-HMO-2219) and a TTD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet website http:/www.hmohelp.ca.gov has complaint forms, IMR applications forms and instructions online.

*State Fair Hearing

In addition to the grievance processes offered by Molina Healthcare, you have the right to request a Fair Hearing from the State of California at anytime during the process. You have a right to request a Fair Hearing even if you haven't filed a complaint or grievance with Molina Healthcare and/or if a health care service you or your doctor requested has been denied, delayed, or modified. You may request a State Fair Hearing by contacting the California Department of Social Services (CDSS) within ninety (90) days. You may write or call CDSS, toll-free, at any time during the grievance process, at the following address and telephone number:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 1937
Sacramento, CA 94244-2340
1 (800) 952-5253 (Voice)
1 (800) 952-8349 (TDD)

You have the right to bring someone who knows about your case to attend the hearing with you, if you wish. You may also seek legal counsel to represent you. For more information on obtaining free legal aid, contact CDSS at their toll-free number.

If you are currently receiving a medical service that is going to be reduced or stopped, you may continue to receive the same medical service until the hearing, as long as you request the hearing before the effective date of the action.

You or your provider may request an Expedited State fair Hearing by calling, writing or faxing Department of Social Services, Expedited Hearing Unit, 744 P Street, MS 19-65, Sacramento, CA 95814, Fax 1-916-229-4267. Molina or your provider must indicate that taking the time for a standard resolution could seriously jeopardize your life or health or ability to attain, maintain or regain maximum function. When Expedited Hearing Unit determines that your appeal satisfies the expedite criteria and when all necessary clinical information has been received by the Unit, the expedited hearing will be scheduled. If the criteria are not met, it will be scheduled for a routine State Fair Hearing as described above.

*External Independent Review

Experimental and investigational therapies may be denied when determined not to be medically necessary. However, California law entitles you to request and obtain an external independent review of that coverage decision through the independent medical review ("IMR") process administered by the Department of Managed Health Care (DMHC) if your physician certifies that you have a life-threatening or seriously debilitating condition and further certifies that standard therapies have not been effective or do not exist with respect to your condition, or there is no more beneficial therapy than the therapy proposed. If experimental and investigational therapies are denied, we will notify you within five (5) days of your right to request and obtain an external independent review of that decision by an entity accredited by the State of California. And, you may contact Molina Healthcare at 1 (888) 665-4621. If you are hearing impaired, call our dedicated TTY line at 1 (800) 479-3310, Monday through Friday, 7:00 a.m. to 7:00 p.m., for information on this subject.

External independent review of a denial of experimental or investigational therapies will be completed within thirty (30) days of your request for review. However, if your physician determines that delay in the proposed therapy would be harmful if not promptly initiated, the external independent review may be expedited to provide a determination within seven (7) days of your request for expedited review.

You will be eligible to participate in Molina Healthcare's external independent review system to examine a coverage decision regarding experimental and investigational therapies if you meet all of the following eligibility criteria:

1. You have either:
   - A. A life-threatening condition, which includes either (1) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or (2) diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival; or
   - B. A seriously debilitating condition, which means diseases or conditions that cause major irreversible morbidity; and
2. Your physician certifies that you have a condition, as defined in paragraph (1) above, for which standard therapies have not been effective in improving your condition, would not be medically appropriate for you, or for which there is no more beneficial standard therapy covered by Molina Healthcare than the therapy proposed pursuant to paragraph (3) below; and
3. Either:
   - A. Your physician, who is under contract with or employed by Molina Healthcare, has recommended a drug, device, procedure, or other therapy that the physician certifies in writing is likely to be more beneficial to you than any available standard therapies, or
   - B. You, or your physician who is a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from the medical and scientific evidence, as defined in subdivision (d) of Health and Safety Code Section 1370.4, is likely to be more beneficial for you than any available standard therapy. The physician certification pursuant to this subdivision shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation. Nothing in this subdivision shall be construed to require Molina Healthcare to pay for the services of a non-participating physician provided pursuant to this subdivision, that are not otherwise covered pursuant to Molina Healthcare contract; and you have been denied coverage by Molina Healthcare for a drug, device, procedure or other therapy recommended or requested pursuant to paragraph (3) above; and
4. The specific drug, device, procedure or other therapy recommended pursuant to paragraph (3) above would be a covered service, except for Molina Healthcare's determination that the therapy is experimental or investigational.

Please note that you will have the right to submit evidence in support of your request for external independent review. You should also be aware that the external independent review system does not replace Molina Healthcare's grievance process. Rather, the external independent review system is available in addition to Molina Healthcare's grievance process.

*Department of Health Care Services (DHCS) Assistance

The California Department of Health Care Services (DHCS) is available to provide assistance in investigating and resolving any complaints or grievances you may have regarding your care and services. If you wish to use the services of the DHCS to address your concerns, complaints, or grievances, please call the Medi-Cal Managed Care Ombudsman toll-free at 1 (888) 452-8609, Monday through Friday, between the hours of 8:00 a.m. and 5:00 p.m. (Hearing impaired members can reach the DHCS Ombudsman by calling the California Relay Services at 711 for TTY assistance).

State Regulations Available

State regulations, including those covering state hearings, are available at the local office of the county welfare department.

Authorized Representative

Members can represent themselves at the state hearing. They can also be represented by a friend, attorney, or any other person, but are expected to arrange for the representative themself. Members can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response Unit (800) 952-5253.

MEMBER GRIEVANCE

The Department of Managed Health Care (DMHC) has amended the California Knox-Keene Health Care Service Plan Act pertaining to health plan member grievance procedures. Under this amendment, health plans are required to distribute the Plan's Member Grievance Procedures and Member Grievance/Complaint Forms to participating Providers/Practitioners.

Potential Quality of Care Issue

Molina Healthcare recognizes that PQOCs may be identified through a multitude of inputs internally and externally, including Provider/Practitioner grievances or complaints and member grievances or complaints. For this reason, Molina Healthcare's Quality Improvement Program includes input from both Provider Services and Member Services to identify both individual or incident-specific PQOCs, as well as identifying specific trends.

Member Grievance System

Molina Healthcare members' grievances are addressed through Molina Healthcare's internal grievance process. A member grievance is defined as member expression of any dissatisfaction, or concern that does not involve a prior determination or inquiry that was not resolved to the member's satisfaction. Examples of this include, but are not limited to appointment/office waiting time, Provider/Practitioner behavior and demeanor, adequacy of facilities, operations, and service. Molina Healthcare will investigate member grievances, attempt to resolve the concerns, and take action as appropriate resolutions and findings are considered confidential and are privileged under California law. A member must not be discriminated against because he/she has filed a member grievance.

Member Grievance Submission

Member grievances may be submitted to Molina Healthcare verbally, via email, on the Molina Healthcare website, or in writing. Members or the Provider/Practitioner on behalf of the member may call the Molina Healthcare Member Services Department for assistance in lodging a grievance. Members may obtain a complaint form from their Primary Care Practitioner's (PCP's) office, the Molina Healthcare website, or they may call the Molina Healthcare Member Services Department to receive these forms. Once the member grievance is received by the Member Services Department, the grievance is submitted to the appropriate departmental contact for investigation.

Molina Healthcare will provide the member with written notification acknowledging the member grievance within five (5) working days of its receipt. The member will be informed in writing of the proposed resolution or outcome of the grievance within thirty (30) days.

It is important to note that a member grievance may be a potential quality of care or service issue and PCPs, as well as their office staff, should be ready to assist a member with needed information. As a PCP, you must have Molina Healthcare grievance forms in your office conveniently located for your members or they can also be found on the Molina Healthcare website. If you need to order grievance forms, please contact Molina Healthcare's Provider Services Department at (888) 665-4621.

Member complaints may include, but are not limited to:

- Excessive waiting time in a Provider/Practitioner's office.
- Inappropriate behavior and/or demeanor (PCP's/Office Staff's).
- Denied services. Clinical grievance subject to member/Provider/Practitioner appeal of the UM decision and expedited appeal of the UM decision.

- Inadequacy of the facilities, including appearance.
- Any problem that the member is having with Molina Healthcare or their IPA/Medical Group, contracted Providers/Practitioners.
- Members billed for covered services.

Attachments/Exhibits:

Sample Grievance/Complaint Forms in English, Spanish, Russian, Chinese, Arabic, Hmong, and Vietnamese

Further Information

If you have any questions regarding the member grievance processing or if you would like a copy of the Molina Healthcare Member Handbook. Please call Member Services at (888) 665-4621, Monday-Friday 7:00 am to 7:00 pm.

MOLINA HEALTHCARE'S OMBUDSMAN PROGRAM

Providers/Practitioners

A Provider/Practitioner with a concern, question, or complaint should contact his/her Molina Healthcare Provider Services Representative by calling the Provider Services Department toll-free at (888) 665-4621.

Should the concern, question or complaint not be addressed to the Provider/Practitioner's satisfaction, the Provider/Practitioner may call the Molina Healthcare Ombudsman toll-free at (877) 665-4627 or write to the following address:

Molina Healthcare of California
Ombudsman Program
200 Oceangate, Suite 100
Long Beach, CA 90802

The Ombudsman attempts to ensure that Molina Healthcare has made an appropriate effort to address Provider/ Practitioner concerns and provide quality customer service.

The Ombudsman is not a substitute for any Molina Healthcare department or process. As previously stated, Providers/Practitioners should first contact Provider Services before seeking Ombudsman assistance.

Health Plan Members

If a Molina Healthcare member has a concern, question, or complaint related to his health care, he should first contact the Member Services Department toll-free at (888) 665-4621, Monday-Friday 7:00 am to 7:00 pm.

In the event a member is unsure of how to proceed with a concern and/or believes Member Services did not fully understand his/her concern, the member may call the Ombudsman toll-free at (877) 665-4627. The member may also write to:

Molina Healthcare of California
Ombudsman Program
200 Oceangate, Suite 100
Long Beach, CA 90802

The Ombudsman attempts to ensure that Molina Healthcare has made an appropriate effort to address member concerns and provide members with quality customer service.

The Ombudsman is not a substitute for any Molina Healthcare department or process. As previously stated, members should first contact the Member Services Department before seeking Ombudsman assistance.