



ADMINISTRATIVE APPEALS

Administrative Denials

Molina Healthcare of Michigan has a one (1) level appeal process for the practitioner appeal of post-service administrative denials.

Level 1

- A. A practitioner must submit a written appeal within 90 days of the denial notification to:
Molina Healthcare of Michigan
Utilization Management Appeals
100 West Big Beaver, Suite 600
Troy, MI 48084
- B. The appeal must include new supporting evidence and/or documentation justifying the service, care or treatment being appealed, and reason for notification outside of Molina Healthcare notification timeframes. Portions of the medical record may be submitted.
- C. Upon receipt of the appeal, the Medical Director, or other qualified physician, will review all documentation submitted and fully investigate all aspects of the clinical care provided without deference to the original determination.
- D. The Medical Director, or other qualified physician, will/may consult with a physician of the same or similar specialty as the case in review.
- E. A decision will be rendered and written notification provided within 30 calendar days of the receipt of a post-service appeal.

Expedited Appeal: Molina Healthcare of Michigan will expedite an appeal and render a decision within 72 hours of the request if a longer timeframe could seriously jeopardize the life or health of the member or would subject the member to severe pain that cannot be adequately managed without the care that is subject of the request.

Rights to copies of documents: A practitioner may request Molina Healthcare of Michigan to furnish all documents relevant to the member's appeal as well as copies of the actual benefit provision, guideline, protocol or criteria on which the appeal decision was based.

Right to know practitioners participating in the appeal: A practitioner may request Molina Healthcare of Michigan to furnish the names, titles and qualifications of any medical experts whose advice was obtained on behalf of Molina Healthcare of Michigan in connection with the appeal, without regard to whether the advice was relied upon in making the appeal decision.



Medical Necessity Denials

Molina Healthcare of Michigan has a two (2) level appeal process for the practitioner appeal of post-service medical necessity denials.

Level 1

- A. A practitioner must submit a written appeal within 90 days of the denial notification to:
Molina Healthcare of Michigan
Utilization Management Appeals
100 West Big Beaver, Suite 600
Troy, MI 48084
- B. The appeal must include new supporting evidence and/or documentation justifying the service, care or treatment being appealed. Portions of the medical record may be submitted.
- C. Upon receipt of the appeal, the Medical Director, or other qualified physician, will review all documentation submitted and fully investigate all aspects of the clinical care provided without deference to the original determination.
- D. The Medical Director, or other qualified physician, will/may consult with a physician of the same or similar specialty as the case in review.
- E. A decision will be rendered and written notification provided within 30 calendar days of the receipt of a post-service appeal.

Level 2

- A. If you disagree with the decision at Level 1, a practitioner must submit a second written appeal within 90 days of the date of the Level 1 denial notice to the same address as listed in Level 1. The request must clearly state it is for a Level 2 review.
- B. The written request must include additional supporting documentation justifying the need for the denied service.
- C. The appeal will/may be reviewed by a Medical Director or by a consultant of same or similar specialty.
- D. The Medical Director will render a decision and written notification will be provided within 30 calendar days of the receipt of a post-service appeal.

Expedited Appeal: Molina Healthcare of Michigan will expedite an appeal and render a decision within 72 hours of the request if a longer timeframe could seriously jeopardize the life or health of the member or would subject the member to severe pain that cannot be adequately managed without the care that is subject of the request.

Rights to copies of documents: A practitioner may request Molina Healthcare of Michigan to furnish all documents relevant to the member's appeal as well as copies of the actual benefit provision, guideline, protocol or criteria on which the appeal decision was based.

Right to know practitioners participating in the appeal: A practitioner may request Molina Healthcare to furnish the names, titles and qualifications of any medical experts whose advice was obtained on behalf of Molina Healthcare in connection with the appeal, without regard to whether the advice was relied upon in making the appeal decision.



Timely Filing Appeals

Providers may submit an appeal for timely filing and/or coding edit (CCI edit denials) by following the steps below:

- Timely Filing appeals must be submitted with supporting documentation showing claim was filed in a timely manner.
- Complete a Claims Adjustment Request Form, or submit an appeal letter with supporting documentation.
- **Mail your Timely Filing appeal to:**
Molina Healthcare
Attention: Claims Department
100 W. Big Beaver Road, Suite 600
Troy, MI 48084-5209
- **Or fax to : 248- 925- 1768 Attention Timely Filing appeal**

Code Edit Appeals (CCI Edits)

- CCI Edit appeals must be submitted with supporting documentation and medical notes/reports.
 - Only submit non corrected claims as appeals
 - Complete a Claims Adjustment Request Form, or submit an appeal letter with supporting documentation.
- Mail your CCI Edit appeal to:**
Molina Healthcare
Attention: Claims Department
100 W. Big Beaver Road, Suite 600
Troy, MI 48084-5209
- **Or fax to : 248- 925- 1768 Attention CCI Edit appeal**

Rapid Dispute Resolution

Plan supports the Michigan Department of Community Health (MDCH) Rapid Dispute Resolution Process (RDRP) for hospitals under the MDCH Access Agreement. The purpose of this policy and procedure is to ensure Provider disputes are processed in a timely and efficient manner with adherence to State/Federal Regulations. Provider disputes will be reviewed to determine the appropriate resolution.