



APPEALS AND GRIEVANCES

Appeals, Grievances, and State Hearings

Molina Healthcare of Ohio, Inc. (Molina Healthcare) members, member representatives and participating providers have the right to voice a grievance, or submit an appeal through a formal process. This section addresses the identification, review and resolution of member grievances and appeals.

MEMBER APPEALS AND GRIEVANCES

Grievances (complaints) are defined by the Ohio Department of Job and Family Services (ODJFS) as an expression of dissatisfaction with any aspect of Molina Healthcare or a participating provider's operations, provision of health care services, activities or behaviors.

Molina Healthcare members have the right to file a grievance by calling Molina Healthcare's Member Services Department at 1-800-642-4168 (TTY for the hearing impaired: 1-800-750-0750).

Members may also submit their grievance in writing to:
Molina Healthcare of Ohio, Inc.
Attn: Appeals and Grievance Department
PO Box 349020
Columbus, Ohio 43234-9020

Members may authorize a designated representative to act on their behalf (hereafter referred to as "representative"). The representative can be a friend, a family member, health care provider, or an attorney. Members must complete a Health Insurance Portability and Accountability Act (HIPAA) compliant authorization designation form to enact this process. Molina Healthcare can provide the form as needed.

Molina Healthcare will research and resolve the grievance and notify the member or representative of the findings within the following timeframes:

- Two (2) working days of receipt of the grievance if it is regarding access to Medicaid covered services.
- Thirty (30) calendar days of receipt for grievances that are not claims related.
- Sixty (60) calendar days for grievances regarding claims.

Molina Healthcare will attempt to provide verbal communication of the grievance resolution to the member or representative when appropriate. If Molina Healthcare is unable to reach the member, or if the grievance was originally submitted in writing, Molina Healthcare will provide written communication of the grievance resolution.

If the grievance resolution affirms the denial, reduction, suspension, or termination of a Medicaid-covered service, or if the resolution permits the billing of a member due to Molina Healthcare's denial of payment for that service, Molina Healthcare will notify the member of their right to request a state hearing.

All grievances received will be kept confidential, except as needed to resolve the issue and respond to the member or representative.

Interpreter services are available to assist members with filing a grievance.

Appeals are the request for review of an action. The member, representative or a provider acting on behalf of the member has the right to appeal Molina Healthcare's decision to deny a service. An appeal can be filed verbally or in writing within 90 days from the date of the Notice of Action. Molina Healthcare must acknowledge the receipt of an appeal verbally or in writing if received in writing. Molina Healthcare will respond to the member or representative in writing with a decision within 15 days (unless an extension is granted to Molina Healthcare by ODJFS).

Members or representatives may call member services at 1-800-642-4168 (TTY for the hearing impaired: 1-800-750-0750) with their appeal or submit the appeal in writing to:

Molina Healthcare of Ohio, Inc.
Attn: Appeals and Grievance Department
PO Box 349020
Columbus, Ohio 43234-9020

An Appeal Representative Authorization Form must be completed and signed by the member within 15 days of receipt of the appeal in order to allow someone else to file an appeal on his/her behalf. Lack of written consent does not pose any barrier to the member's appeal process; however, if it is not received within the time frame, the appeal request will be closed and there will be no determination. This form is available online at www.MolinaHealthcare.com.

The member or representative should state the reason they feel the service should be covered. For a copy of the Grievance and Appeal (Complaint) Form, see the Forms section of this manual.

Molina Healthcare has an expedited process for reviewing appeals when the standard resolution timeframe could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function.

Expedited appeals may be requested by the member or representative orally or in writing. Molina Healthcare will promptly inform the member or representative of the decision whether to expedite the appeal within one (1) working day of receipt. With few exceptions, an expedited appeal will be resolved as expeditiously as the member's health condition requires but will not exceed three (3) working days from date of receipt. If Molina Healthcare denies the request for an expedited resolution of an appeal, the appeal will be transferred to the standard resolution timeframe of 15 calendar days from the date the appeal was received (unless an extension was granted). The member or representative will be notified of an expedited resolution within 72 hours of Molina Healthcare's receipt.

No punitive action will be taken against a member or representative for filing an expedited appeal.

A member has the right to request a state hearing from the Bureau of State Hearings any time there is dissatisfaction with Molina Healthcare's decision. It is not necessary for a member or representative to file an appeal prior to requesting a state hearing.

Members are notified of their right to a state hearing in all of the following situations:

- A service denial (in whole or in part)

- Reduction, suspension or termination of a previously authorized service
- A member is being billed by a provider due to a denial of payment and Molina Healthcare upholds the decision to deny payment to the provider

A health care provider may act as the member's authorized representative or as a witness for the member at the hearing.

Appeal decisions not wholly resolved in the member's favor will include information on how to request a state hearing and instructions on how to continue receiving benefits if benefits were denied until the time the state hearing is scheduled. If the state hearing upholds Molina Healthcare's decision and continued benefits were requested in the interim, the member may be responsible for payment.