

Chapter 10 ***Complaints and Appeals***

A. Medicaid Member Complaints and Appeals

Medicaid (STAR & STAR+Plus) Member Complaints

Complaint (Medicaid) means an expression of dissatisfaction, expressed by a Complainant, orally or in writing to the HMO, about any matter related to the HMO other than an Action. Possible subjects for Complaints include, but are not limited to, the quality of care of services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Medicaid Member’s rights.

How to file a Medicaid complaint:

- A Member has the right to file a complaint with Molina or HHSC
- A complaint can be oral or written:

Who to Call:

MOLINA	HHSC
Call: 1-866-449-6849	Call: 1-800-252-8263
Write to: Molina Health Care of Texas 84 NE Loop 410, Suite 200 Attn: Member Complaints San Antonio, TX 78216	Write to: HHSC PO Box 85200 Austin, TX 78708

Complaint Timeframes (Medicaid):

- A Member or the Member’s representative can file a complaint anytime.
- When Molina Healthcare of Texas receives a complaint from a member, or the member’s representative we will send an acknowledgement letter to the member within 5 business days.
- Complaints will be investigated, addressed, and the member will be notified of the outcome, in writing, within 30 calendar days from the date the complaint is received by Molina Healthcare of Texas.

Assistance with Filing a Medicaid Complaint:

- Molina Healthcare of Texas's Member Services Department will assist a member with filing a complaint. The member can receive assistance by calling our Member Services Department, toll-free number at, 1-866-449-6849.
- Molina Healthcare of Texas also has dedicated employees, called Member Advocates to assist members with the complaint process. A Member Advocate will assist the member with filing a complaint, and then help the member track the complaint through the process until the complaint has been addressed.

Medicaid (STAR & STAR+Plus) Member Appeals

Appeal (Medicaid) means the formal process by which a Member or his or her representative request a review of the HMO's Action.

What can be done if Molina limits Member's request for Covered Services?:

If Molina denies or limits a Member's request for covered services, the Member may appeal the decision to deny or limit coverage.

When does a Member have the right to request an appeal?

A Member has the right to request an appeal whenever any of the following Actions are applicable:

Action (Medicaid) includes:

- The denial or limited authorization of a requested Medicaid service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial in whole or in part of payment for services;
- The failure to provide services in a timely manner;
- The failure of an HMO to act within the timeframes set forth in the contract;
- For a resident of a rural area with only one HMO, the denial of a Medicaid Members' request to obtain services outside of the Network.

How will I be notified if services are denied?:

Molina will notify the Member, the Member's Authorized Representative, or the Member's Provider of Record of the Determination.

The notification of the Determination will be called to the requesting provider as well as mailed or faxed no later than two (2) business days after the date of the request for authorization or utilization review is received *and* all medical information necessary to substantiate the need for the requested treatment or services is received by UM department.

A licensed nurse will verbally notify a provider of the offer for a Peer to Peer and provide information on how to reach the MHT Medical Director within 24hrs prior to issuing a denial. If, after the treating and/or attending physician discusses the case with the CMO/Medical Director, and the decision for a denial is made, an adverse determination letter is generated and mailed to the member, physician and facility within 24 hours of the determination.

How to File a Medicaid Appeal:

- A Member has the right to file an appeal with Molina or HHSC, if the appeal is regarding a utilization management decision, the appeal must be received in writing to the health plan address below.
- Every oral appeal received must be confirmed by a written, signed Appeal by the Member or his or her representative, unless the Member or his or her representative requests an expedited resolution:
- At any time during the appeal process a member can request a fair hearing with HHSC

Note: The enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.

MOLINA	HHSC
Call: 1-866-449-6849	Call: 1-800-252-8263
Write to: Molina Health Care of Texas 84 NE Loop 410, Suite 200 Attn: Member Appeals San Antonio, TX 78216	Write to: HHSC Appeals Division, Fair Hearing Y-613 P.O. Box 149030 Austin, TX 78714

Appeal Timeframes (Medicaid):

- A Member must file an Appeal with Molina within 30 days from receipt of the notice of the action. A member or the provider acting as a member’s representative must file an appeal regarding a utilization management decision within 30 days from receipt of the notice of the Action. If the request is sent within 10 days, the member may continue services.
- To ensure continuation of currently authorized services, however, the member must file the Appeal on or before the later of 10 days following Molina’s mailing of the notice of Action, or the intended effective date of the proposed Action.
- When Molina Healthcare of Texas receives an appeal from a member, or the member’s representative an acknowledgement letter to the member within 5 business days. Within 5 days of receipt of the appeal request, the member will be sent an acknowledgement letter that includes the following information:
 - The appeal process,
 - Member’s right to review the records,

- Member's right to submit additional information
 - When Member will receive a response
 - Member's right to request a fair hearing.
- Within 30 days of receipt of the appeal request the member will be sent a resolution letter unless there is a clinically urgent need to resolve the appeal sooner. Then the appeal will be resolved based on the clinical urgency of the appeal. The appeals resolution letter will contain the following information:
 - If the denial was upheld, the clinical reason why,
 - The specialty of the person who reviewed the case
 - Member's rights to appeal further
 - Appeals will be investigated, addressed and the member will be notified of the outcome, in writing, within 30 business days from the date the appeal is received by Molina Healthcare of Texas.
 - The timeframe to resolve a standard appeal can be extended up to 14 calendar days if the Member or Member's representative requests an extension; or Molina shows that there is a need for additional information and how the delay is in the Member's interest.
 - **At any time during the standard appeals process with MHT, a member may request a fair hearing with the state of Texas.**

Can someone from Molina Healthcare help me file an Appeal?:

- Molina Healthcare of Texas's Member Services Department will assist a member with filing an appeal or answer questions related to appeals. The member can receive assistance by calling our Member Services Department, toll-free number at 1-866-449-6849
- Molina Healthcare of Texas also has dedicated employees, called Member Advocates to assist members with the appeal process. A Member Advocate will assist the member with filing an appeal, and then help the member track the appeal through the process until the appeal has been resolved.

Expedited Medicaid Appeals

Expedited Appeal (Medicaid) means an appeal to the HMO in which the decision is required quickly based on the Member's health status, and the amount of time necessary to participate in a standard appeal could jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. An expedited appeal may be filed orally or in writing when taking time for a standard resolution could seriously jeopardize the Member's life or health. When the member or their representative files an expedited appeal, Molina will notify the member or their representative of the outcome within three business days of receipt of the request for an expedited appeal. However, if the request for an expedited appeal is related to an ongoing emergency or a denial of a continued hospital stay, in accordance with the medical or dental immediacy of the case, Molina will send the member (or member's representative) a resolution no later than one business day after receiving the request for an expedited appeal. There may be some cases where we may need up to 14 business days to collect additional clinical information. This additional time may be granted if the delay is in the best interest of the member. If the decision to deny is upheld, the resolution letter will contain information for the member on how to request an expedited Fair hearing with the State.

How to File an Expedited Medicaid Appeal:

- A Member has the right to file an expedited appeal with Molina. Molina’s expedited appeal process must be complete prior to requesting a fair hearing:
- Expedited appeals can be filed orally or in writing.

MOLINA	HHSC
Call: 1-866-449-6849	Call: 1-800-252-8263
Write to: Molina Health Care of Texas 84 NE Loop 410, Suite 200 Attn: Member Appeals San Antonio, TX 78216	Write to: HHSC Appeals Division, Fair Hearing Y-613 P.O. Box 149030 Austin, TX 78714

Expedited Medicaid Appeal Timeframes:

Molina must acknowledge receipt of the Member’s request for an expedited appeal within one business day.

- After Molina receives the request for an Expedited Appeal, it must notify the Member of the outcome of the Expedited Appeal within 3 business days.
- Except Molina must complete investigation and resolution of an Expedited Appeal relating to an ongoing emergency or denial of continued hospitalization: (1) in accordance with the medical or dental immediacy of the case; and (2) not later than one (1) business day after receiving the Member’s request for Expedited Appeal is received.
- Except for an Expedited Appeal relating to an ongoing emergency or denial of continued hospitalization, the timeframe for notifying the Member of the outcome of the Expedited Appeal may be extended up to 14 calendar days if the Member requests an extension or Molina shows (to the satisfaction of HHSC, upon HHSC’s request) that there is a need for additional information and how the delay is in the Member’s interest. If the timeframe is extended, Molina must give the Member written notice of the reason for delay if the Member had not requested the delay.

Who can assist me in Filing an Expedited Medicaid Appeal?:

- Molina Healthcare of Texas Member Service Department will assist a member with filing an expedited appeal. The member can receive assistance by calling our Member Services Department, toll-free number at 1-866-449-6849.
- Molina Healthcare of Texas also has dedicated employees, called Member Advocates to assist members with the expedited appeal process. A Member Advocate will assist the member with filing an expedited appeal, and then help the member track the expedited appeal through the process until the appeal has been resolved.

What happens if Molina Healthcare denies the request for an Expedited Appeal?:

- If Molina denies a request for expedited resolution of an appeal, it must
 - Transfer the Appeal to the timeframe for standard resolutions, and
 - Make a reasonable effort to give the Member prompt oral notice of the denial, and follow up within 2 calendar days with a written notice.
- Molina is responsible for notifying the Member of their right to an Expedited Fair Hearing. An Expedited Fair Hearing can not be requested until the Molina member has exhausted Molina's Expedited Appeal Process.

Dissatisfied with STAR, STAR PLUS Complaint or Appeal Outcome?

Upon receipt of the **STAR** complaint outcome, if the provider is still dissatisfied, the provider may contact HHSC or TDI for further resolution. For more information:

Call HHSC at: 1-512-338-6569; Fax: 1-512-794-6815; or
E-mail: provider.resolutions@hhsc.state.tx.us
Texas Health and Human Services Commission
Medical Appeals and Provider Resolution Division, Y-929
1100 West 49th Street
Austin, TX 78756-3172

Medicaid State Fair Hearing (Member Information)

Can I ask for a state fair hearing?

If the Member disagrees with the health plan's decision, the Member has the right to ask for a fair hearing. The Member may appoint, in writing, a representative. A provider may be a Member's representative. The Member or Member Representative must ask for the fair hearing within 90 days of the date on the health plan's letter. If the Member does not ask for the fair hearing within 90 days, the Member may lose his/her right to a fair hearing. To request a fair hearing, the Member or Member representative contacts the health plan in writing or by telephone at:

Molina Healthcare
Calling: 1-866-449-6849
Writing to: Molina Healthcare of Texas Fair Hearing 84 NE Loop 410, Suite 200 San Antonio TX 78216

The Member has the right to continue any service he/she is now receiving until the final hearing decision, if the Member requests the fair hearing within ten days from receipt of the hearing notice from the health plan. If a fair hearing is not requested within ten days from receipt of the hearing notice, the services being appealed will be discontinued.

The Member does not have a right to a Fair Hearing if Medicaid does not cover the service requested.

If the Member asks for a Fair Hearing, the Member will get a packet of information letting the Member know the date, time and location of the hearing. Most fair hearings are held by telephone and the Member or the Member's representative may tell why he/she asked for the service.

HHSC will give the Member a final decision within 90 days from the date the Member asked for the hearing.

B. CHIP Complaints and Appeals

Chip Member Complaints

Complaint (CHIP) means any dissatisfaction, expressed by a Complainant, orally or in writing to the HMO, with any aspect of the HMO's operation, including, but not limited to, dissatisfaction with plan administration, procedures related to review or Appeal of an Adverse Determination, the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or a disenrollment decision. The term does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the CHIP Member.

What should I do if I have a complaint?:

- A Member has the right to file a complaint with Molina or the Texas Department of Insurance (TDI):

Who do I call?:

- A complaint can be oral or written:

MOLINA	TDI
Call: 1-866-449-6849 (toll free) or 210-366-6500	Call: 1-800-252-3439 (toll free) or 1-512-305-6745
Write to: Molina Health Care of Texas 84 NE Loop 410, Suite 200 Attn: Member Complaints San Antonio, TX 78216	Write to: TDI Consumer Protection (111-1A) Po Box 149091 Austin, Texas 78714-9091

How long will it take to process my Complaint?:

- A Member or the Member’s representative can file a complaint anytime.
- When Molina Healthcare of Texas receives a complaint from a member, or the member’s representative we will send an acknowledgement letter to the member within 5 business days.
- Complaints will be investigated, addressed, and the member will be notified of the outcome, in writing, within 30 calendar days from the date the complaint is received by Molina Healthcare of Texas.

Can someone from Molina help me file a CHIP complaint?:

- Molina Healthcare of Texas’s Member Services Department will assist a member with filing a complaint. The member can receive assistance by calling our Member Services Department, toll-free number at, 1-866-449-6849.
- Molina Healthcare of Texas also has dedicated employees, called Member Advocates to assist members with the complaint process. A Member Advocate will assist the member with filing a complaint, and then help the member track the complaint through the process until the complaint has been addressed.

CHIP Member Appeals

What can I do if Molina denies or limits request for a Covered Service?

If Molina denies or limits a request for Covered Service for a member, a Member Appeal may be filed by the Member, or Member’s representative.

Appeal (CHIP) means the formal process by which a Utilization Review agent addresses Adverse Determinations.

Adverse Determination (CHIP) means a determination by an HMO or Utilization Review agent that the Health Care Services furnished, or proposed to be furnished to a patient, are not Medically Necessary or not appropriate.

How will I be notified if services are denied?:

Molina will notify the Member, the Member’s Authorized Representative, or the Member’s Provider of Record of the Determination.

The notification of the Determination will be mailed or faxed no later than two (2) business days after the date the request for authorization or utilization review is received *and* all medical information necessary to substantiate the need for the requested treatment or services is received by UM department.

A licensed nurse will verbally notify a provider of the offer for a Peer to Peer and provide information on how to reach the MHT Medical Director within 24hrs prior to issuing a denial. If, after the treating and/or attending physician discusses the case with the CMO/Medical Director, and the decision for a denial is made, an adverse determination letter is generated and mailed to the member, physician and facility within 24 hours of the determination.

How to file a CHIP appeal/When Members Have the Right to Appeal:

- A Member has the right to file an appeal with Molina or the Texas Department of Insurance (TDI) when they believe denied services are medically necessary or should be covered by Molina:
- Every oral appeal received must be confirmed by a written, signed Appeal by the Member or his or her representative, unless the Member or his or her representative requests an expedited resolution:
- An appeal can be oral or written:

MOLINA	TDI
Call: 1-866-449-6849	Call: 1-800-252-3439
Write to: Molina Health Care of Texas 84 NE Loop 410, Suite 200 Attn: Member Appeals San Antonio, TX 78216	Write to: TDI Consumer Protection (111-1A) Po Box 149091 Austin, Texas 78714-9091

Appeal Timeframes (CHIP):

- A Member or the Member’s representative can file an appeal anytime.

- When Molina Healthcare of Texas receives an appeal from a member, or the member’s representative, we will send an acknowledgement letter to the member within 5 business days.
- Appeals will be investigated, addressed and the member will be notified of the outcome, in writing, within 30 business days from the date the appeal is received by Molina Healthcare of Texas.

Can someone from Molina help me File a CHIP Appeal?:

- Molina Healthcare of Texas’ Member Services Department will assist a member with filing an appeal. The member can receive assistance by calling our Member Services Department, toll-free number at 1-866-449-6849.
- Molina Healthcare of Texas also has dedicated employees, called Member Advocates to assist members with the appeal process. A Member Advocate will assist the member with filing an appeal, and then help the member track the appeal through the process until the appeal is resolved.

Expedited CHIP Appeals

Expedited Appeal (CHIP) means an appeal to the HMO in which the decision is required quickly based on the Member’s health status, and the amount of time necessary to participate in a standard appeal could jeopardize the Member’s life or health or ability to attain, maintain, or regain maximum function. An expedited appeal may be filed orally or in writing when taking time for a standard resolution could seriously jeopardize the Member’s life or health. When the member or their representative files an expedited appeal, Molina will notify the member or their representative of the outcome within three business days of receipt of the request for an expedited appeal. However, if the request for an expedited appeal is related to an ongoing emergency or a denial of a continued hospital stay, in accordance with the medical or dental immediacy of the case, Molina will send the member (or member’s representative) a resolution no later than one business day after receiving the request for an expedited appeal. There may be some cases where we may need up to 14 business days to collect additional clinical information. This additional time may be granted if the delay is in the best interest of the member. If the decision to deny is upheld, the resolution letter will contain information for the member on how to request an IRO.

How to request an Expedited appeal:

- A Member has the right to file an expedited appeal with Molina.
- Expedited appeals can be filed orally or in writing.

MOLINA	TDI
Call: 1-866-449-6849	Call: 1-800-252-3439
Write to: Molina Health Care of Texas 84 NE Loop 410, Suite 200 Attn: Member Appeals San Antonio, TX 78216	Write to: TDI Consumer Protection (111-1A) Po Box 149091 Austin, Texas 78714-9091

Expedited Appeal Timeframes:

Molina must acknowledge receipt of the Member's request for an expedited appeal within one business day.

- After Molina receives the request for an Expedited Appeal, it must notify the Member of the outcome of the Expedited Appeal within 3 business days.
- Except Molina must complete investigation and resolution of an Expedited Appeal relating to an ongoing emergency or denial of continued hospitalization: (1) in accordance with the medical or dental immediacy of the case; and (2) not later than one (1) business day after receiving the Member's request for Expedited Appeal is received.
- Except for an Expedited Appeal relating to an ongoing emergency or denial of continued hospitalization, the timeframe for notifying the Member of the outcome of the Expedited Appeal may be extended up to 14 calendar days if the Member requests an extension or Molina shows (to the satisfaction of HHSC, upon HHSC's request) that there is a need for additional information and how the delay is in the Member's interest. If the timeframe is extended, Molina must give the Member written notice of the reason for delay if the Member had not requested the delay.

What happens if Molina denies the request for an Expedited Appeal?:

- If Molina denies a request for expedited resolution of an appeal, it must
 - Transfer the Appeal to the timeframe for standard resolutions, and
 - Make a reasonable effort to give the Member prompt oral notice of the denial, and follow up within 2 calendar days with a written notice.
- Molina is responsible for notifying the Member of their right to an IRO review.

Who can assist in filing an Expedited Appeal?

- Molina Healthcare of Texas' Member Services Department will assist a member with filing an appeal. The member can receive assistance by calling our Member Services Department, toll-free number at 1-866-449-6849.
- Molina Healthcare of Texas also has dedicated employees, called Member Advocates to assist members with the appeal process. A Member Advocate will assist the member with filing an appeal, and then help the member track the appeal through the process until the appeal is resolved.

Dissatisfied with CHIP Complaint or Appeal Outcome?

Upon receipt of the **CHIP** complaint outcome, if the provider is still dissatisfied, the provider may contact HHSC or TDI for further resolution. For more information:

Call TDI at: 1-800-232-3439; Fax 1-512-475-1771; or
E-mail: ConsumerProtection@tdi.state.tx.us
Texas Department of Insurance
P.O. Box 149091
Austin, TX 78714-9091

The Complaint and Appeal Coordinator will provide, upon request, a summary of the steps followed internally regarding the grievance to both the provider and HHSC.

External Review by Independent Review Organization (CHIP)

What is an Independent Review Organization (IRO)?

You may be able to have an Independent Review Organization (IRO) review a decision by Molina to not pay for a treatment it considers medically unnecessary or inappropriate. In most cases, you must first appeal to Molina before requesting an IRO review. You can skip the appeal process if you or your doctor believes your condition is life threatening.

How do I request an IRO?

When we or our Utilization Review Agent deny the appeal, you, your designated representative, or your child's provider will receive information on how to request an IRO review of the denial and the forms that must be completed and returned to begin the independent review process.

IRO Review Timeframes:

The entire independent review process should be completed by the IRO, including the IRO's determination, no longer than the earlier of the 15th day after the IRO receives all the information or the 20th day after the IRO receives your request for independent review.

In circumstances involving a Life-threatening condition, your child is entitled to an immediate review by an IRO without having to comply with the procedures for internal appeals of Adverse Determinations. In Life-threatening situations, you, your designated representative or your child's Physician or Provider of record may contact us or our Utilization Review Agent by telephone to request the review by the IRO and we or our utilization review agent will provide the required information. In cases involving a Life-threatening condition, the IRO should complete the entire independent review process and make a determination in no more than 8 calendar days from the date the IRO receives a completed form from you and all the necessary information.

When the IRO completes its review and issues its decision, we will abide by the IRO's decision. We will pay for the IRO review. If you have any questions about the independent review process, you can contact the Texas Department of Insurance at 1-888-TDI-2IRO.

The appeal procedures described above do not prohibit you from pursuing other appropriate remedies, including injunctive relief, declaratory judgment, or other relief available under law, if you believe that the requirement of completing the appeal and review process places your child’s health in serious jeopardy.

C. Provider Complaints and Appeals

Provider Complaints

A provider has the right to file a complaint with Molina HealthCare of Texas at anytime. The provider also has the right to file a complaint directly with HHSC.

How to file a Medicaid Complaint:

Medicaid (STAR and STAR+Plus) complaints

- A complaint can be oral or written:

MOLINA	HHSC
Call: 1-866-449-6849 or 713-418-1999	Call: 1-800-252-8263
Write to: Molina Health Care of Texas 84 NE Loop 410, Suite 200 Attn: Provider Complaints San Antonio, TX 78216	Write to: HHSC Po Box 85200 Austin, TX 78708

How to file a CHIP Complaint:

CHIP complaints

- A complaint can be oral or written:

MOLINA	TDI
Call: 1-866-449-6849	Call: 1-800-252-3439
Write to: Molina Health Care of Texas 84 NE Loop 410, Suite 200 Attn: Provider Complaints San Antonio, TX 78216	Write to: TDI Consumer Protection (111-1A) Po Box 149091 Austin, Texas 78714-9091

Complaint Timeframes:

- A provider can file a complaint anytime.
- When a complaint is received verbally, Molina will send an acknowledgement letter along with a one page complaint form within 5 business days.
- When Molina Healthcare of Texas receives a written complaint from a provider we will send an acknowledgement letter to the provider within 5 business days.
- Complaints will be investigated, addressed, and the provider will be notified of the outcome, in writing, within 30 calendar days from the date the complaint is received by Molina Healthcare of Texas.

Appeal Process

Appeal means the formal process by which a Provider requests a review of the HMO's Action.

Action means:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial in whole or in part of payment for services;
- The failure to provide services in a timely manner;
- The failure of an HMO to act within the timeframes set forth in the contract;
- For a resident of a rural area with only one HMO, the denial of a Medicaid Members' request to obtain services outside of the Network.

How to file an appeal:

- An appeal can be filed in writing or verbally.

MOLINA
Call: 1-866-449-6849
Write to: Molina Health Care of Texas 84 NE Loop 410, Suite 200 Attn: Provider Complaints San Antonio, TX 78216

Appeal Timeframes:

- Provider or Practitioner appeal of a Utilization Management (UM) decision shall be adjudicated in a thorough, appropriate, and timely manner.
- The provider or practitioner is allowed **120 days** from the date of the initial denial notification to submit a first level appeal.
- A first level appeal for decisions made by Molina shall be reviewed by a Medical Director not involved in the initial denial decision.
- The provider or practitioner is allowed **thirty (30) days** from the first level appeal decision notification to submit a second level appeal.
- A second level appeal of a first level appeal decision may be made by an MHT Medical Director or an independent reviewer for reconsideration.

Expedited Appeals (Medicaid)

Expedited Appeal (Medicaid) – Means an appeal to the HMO in which the decision is required quickly based on the Member’s health status, and the amount of time necessary to participate in a standard appeal could jeopardize the Member’s life or health or ability to attain, maintain, or regain maximum function.

How to File an Expedited Appeal:

- A Member or Member’s representative have the right to file an expedited appeal with Molina. Molina’s expedited appeal process must be complete prior to requesting a fair hearing:
- Expedited appeals can be filed orally or in writing.

MOLINA	HHSC
Call: 1-866-449-6849	Call: 1-800-252-8263
Write to: Molina Health Care of Texas 84 NE Loop 410, Suite 200 Attn: Provider Complaints San Antonio, TX 78216	Write to: HHSC Appeals Division, Fair Hearing Y-613 P.O. Box 149030 Austin, TX 78714

Expedited Appeal Timeframes:

- Molina must acknowledge receipt of the Member’s request for an expedited appeal within one business day.
- After Molina receives the request for an Expedited Appeal, it must notify the Member of the outcome of the Expedited Appeal within 3 business days.
- Except Molina must complete investigation and resolution of an Expedited Appeal relating to an ongoing emergency or denial of continued hospitalization: (1) in accordance with the medical or dental immediacy of the case; and (2) not later than one (1) business day after receiving the Member’s request for Expedited Appeal is received.

- Except for an Expedited Appeal relating to an ongoing emergency or denial of continued hospitalization, the timeframe for notifying the Member of the outcome of the Expedited Appeal may be extended up to 14 calendar days if the Member requests an extension or Molina shows (to the satisfaction of HHSC, upon HHSC's request) that there is a need for additional information and how the delay is in the Member's interest. If the timeframe is extended, Molina must give the Member written notice of the reason for delay if the Member had not requested the delay.

External Review by Independent Review Organization (CHIP)

What is an Independent Review Organization (IRO)?

The Member may be able to have an Independent Review Organization (IRO) review a decision by Molina to not pay for a treatment it considers medically unnecessary or inappropriate. In most cases, the Member or Member's representative must first appeal to Molina before requesting an IRO review. The Member can skip the appeal process if the Member's doctor believes the condition is life threatening.

How To Request an IRO Review:

When Molina or Molina's Utilization Review Agent deny the appeal, the Member, Member's designated representative, or your child's provider will receive information on how to request an IRO review of the denial and the forms that must be completed and returned to begin the independent review process.

IRO Review Timeframes:

The entire independent review process should be completed by the IRO, including the IRO's determination, no longer than the earlier of the 15th day after the IRO receives all the information or the 20th day after the IRO receives the request for independent review.

In circumstances involving a Life-threatening condition, the child is entitled to an immediate review by an IRO without having to comply with the procedures for internal appeals of Adverse Determinations. In Life-threatening situations, Member, Member's designated representative or your child's Physician or Provider of record may contact Molina or Molina's Utilization Review Agent by telephone to request the review by the IRO and Molina or Molina's utilization review agent will provide the required information. In cases involving a Life-threatening condition, the IRO should complete the entire independent review process and make a determination in no more than 8 calendar days from the date the IRO receives a completed form and all the necessary information.

When the IRO completes its review and issues its decision, Molina will abide by the IRO's decision. Molina will pay for the IRO review. If you have any questions about the independent review process, you can contact the Texas Department of Insurance at: 1-888-TDI-2IRO.

The appeal procedures described above do not prohibit the Member from pursuing other appropriate remedies, including injunctive relief, declaratory judgment, or other relief available under law, if he/she believes that the requirement of completing the appeal and review process places the child's health in serious jeopardy.

Additional Resolution Options

Dissatisfied with STAR, STAR PLUS Complaint or Appeal Outcome?

Upon receipt of the **STAR** complaint outcome, if the provider is still dissatisfied, the provider may contact HHSC or TDI for further resolution. For more information:

Call HHSC at: 1-512-338-6569; Fax: 1-512-794-6815; or
E-mail: provider.resolutions@hhsc.state.tx.us
Texas Health and Human Services Commission
Medical Appeals and Provider Resolution Division, Y-929
1100 West 49th Street
Austin, TX 78756-3172

Dissatisfied with CHIP Complaint or Appeal Outcome?

Upon receipt of the **CHIP** complaint outcome, if the provider is still dissatisfied, the provider may contact HHSC or TDI for further resolution. For more information:

Call TDI at: 1-800-232-3439; Fax 1-512-475-1771; or
E-mail: ConsumerProtection@tdi.state.tx.us
Texas Department of Insurance
P.O. Box 149091
Austin, TX 78714-9091

The Complaint and Appeal Coordinator will provide, upon request, a summary of the steps followed internally regarding the grievance to both the provider and HHSC.