# Member and Practitioner/Provider Complaints and Appeals

This section describes the process to be utilized by practitioners/providers who are assisting Members with complaints and appeals, as well as for practitioners/providers who are themselves filing a complaint or appeal on their own behalf. The processes for Members will be discussed first. Practitioners/providers' own complaint and appeal processes can be found at the end of the section.

A **complaint (also known as a grievance)** is any dissatisfaction voiced by any Member on any aspect of his/her health care or health benefits plan *other* than a request for services.

An **appeal** is a request for review of a denied specific health care service or non-payment for a health care service.

Complaints and appeals are reviewed and resolved to promote Member and practitioner/provider satisfaction, in compliance with applicable state and federal law, regulations and guidelines. Complaints are processed in a confidential manner. Molina Healthcare of New Mexico, Inc. (Molina Healthcare) employees are required to sign a confidentiality statement at the time of hire.

No person shall be subject to retaliatory action by Molina Healthcare for any reason related to complaints or appeals.

## Assisting Molina Healthcare Members When They Have a Complaint or Appeal

When practitioners/providers are trying to help a patient get claims paid, a service covered, or a complaint or appeal addressed, Molina Healthcare Member complaint or appeal processes apply. The Member may select someone of his/her choosing, including an attorney (at the Member's expense), to represent his/her complaint or appeal. If someone other than the Member files a complaint on the Member's behalf, an authorization to represent the Member must be submitted to Molina Healthcare. ***If you are filing the complaint or appeal on behalf of a Member, you must submit a signed authorization form from the Member before Molina Healthcare can accept the complaint or appeal request. A copy of that form is included in this section for your convenience, and is also available on the Molina Healthcare website at www.molinahealthcare.com***

# Member and Practitioner/Provider Complaints and Appeals (*continued*)

If you receive a complaint or an issue from a Molina Healthcare Member, please ask the Member to contact the Molina Healthcare Member Services Department. If a Member is unable to call Molina Healthcare for any reason, we ask that you take the basic information about the complaint or appeal from the Member. A form for written complaints or appeals is included in this section for your convenience. Upon filling out the form, practitioners/providers can either call in the information to Molina Healthcare, or the information may be sent via mail or fax to the attention of the Appeals Department at the address or fax number listed in this section.

The Member, the legal guardian of the Member, in the case of minors or incapacitated adults, the Member's practitioner/provider, or the representative of the Member with the Member's written consent, has the right to file a written or oral complaint or appeal to Molina Healthcare or to the Human Services Department (HSD) Hearings Bureau on behalf of the Member. This information is also provided to Members in the Member Handbook. As previously discussed, if you are filing the complaint or appeal on behalf of the Member, you must submit a signed authorization form from the Member before Molina Healthcare can accept the complaint or appeal request. A copy of that form is included in this section for your convenience.

## Filing a Formal Verbal or Written Complaint or Appeal for Members

The Member or representative of the Member, with the Member's written consent, has the right to file a formal verbal or written complaint or appeal if they are dissatisfied with some aspect of Molina Healthcare (i.e., practitioner/provider, or health care received or requested and not received). A network practitioner/provider also has the right to file a formal verbal or written appeal with Molina Healthcare, on the Member's behalf with the Member's written consent, if he/she is dissatisfied with Molina Healthcare's decision to terminate, suspend, reduce, or not provide services to a Member.

# Member and Practitioner/Provider Complaints and Appeals (*continued*)

To submit a formal verbal or written complaint or appeal on behalf of a Molina Healthcare Member, call or write to:

**Molina Healthcare of New Mexico, Inc.**
**Albuquerque: (505) 342-4681**
**Toll free: (800) 580-2811**

**Molina Healthcare of New Mexico, Inc.**
**Attn: Appeals Department**
**P.O. Box 3887**
**Albuquerque, NM 87190-9859**
**Fax (in Albuquerque): (505) 342-0583**

Basic information needed when initiating a formal verbal or written complaint or appeal on behalf of a Member:

- Member name;
- The Member's Molina Healthcare identification number;
- Telephone number (where Member can be reached during the day); and
- A brief description of the issue(s).

All formal verbal or written complaints and appeals are to be reported to Molina Healthcare. Molina Healthcare relies on the assistance of practitioners/providers in facilitating the notification process as well as helping to resolve the Member's issues as quickly as possible. If a practitioner/provider or someone other than the Member files a formal verbal or written complaint or appeal on any Member's behalf, an authorization to represent that Member must be submitted to Molina Healthcare.

When practitioners/providers assist a Molina Healthcare Member in trying to get a service covered, or a formal verbal or written complaint or appeal addressed, Molina Healthcare Member complaints and appeal processes apply. At any level of the formal verbal or written complaint and appeal process, the Member can select someone of his/her own choosing to represent him/her. This includes the legal guardian of the Member in the case of a minor or incapacitated adult, providers/practitioners working on behalf of the Member with the Member's written permission, and/or an attorney (at the Member's expense) to represent him/her.

# Member and Practitioner/Provider Complaints and Appeals (*continued*)

Please contact Molina Healthcare if any Member needs the complaint and appeal information in a language other than English. Translation Services and Teletype/ Telecommunication Device for the Deaf (TTY/TDD) services for the hearing impaired are also available.

## Accessing TTY/TDD Services

Our Complaint and Appeal Line is accessible to all Members. Deaf, hard of hearing, or speech-disabled Members can communicate with Molina Healthcare through the Relay New Mexico (Relay NM) Network. This service is available twenty-four (24) hours a day, seven (7) days a week. Members may access Relay NM by following these directions:

- Using your TTY text telephone, call the Relay NM operator **toll free at (800) 659-8331**;
- Type your message to the Relay NM operator, informing him/her that you would like to contact the Molina Healthcare Member Services Department in **Albuquerque at (505) 341-7493 or toll free at (888) 825-9266;**
- The Relay NM operator voices the typed conversation to the Molina Healthcare Member Service Representative answering the call;
- The Member Service Representative can converse with the Member through the Relay NM operator, who then types the verbal communication to the Member; or
- Molina Healthcare Appeals Staff can also contact Members using the TTY text telephone by calling Relay NM **toll free at (800) 659-1779**, and asking the Relay NM Operator to call the Member and type the conversation to the Member.

Conversations are kept confidential by Molina Healthcare and Relay NM. Relay NM does not maintain records of actual conversations.

## Expedited Review Processes

Internal expedited reviews on pre-service denials will be completed for all Members in accordance with the medical urgency of the case and shall not exceed seventy-two (72) hours whenever:

- The life or health of a covered person may be jeopardized; and
- The covered person's ability to attain, maintain or regain maximum function may be jeopardized. Such determination is based on:
  - A request from the Member;
  - A practitioner/provider's support of the Member's request;
  - A practitioner/provider's request on behalf of the Member; or
  - Molina Healthcare's independent determination.

# Member and Practitioner/Provider Complaints and Appeals (*continued*)

If the expedited review request is denied, the Member and the practitioner/provider are notified and the review is placed in the standard review timeframe.

**Automatic Appeals –** In accordance with Medical Assistance Division Policy**, if a Member is inpatient and coverage for additional days is denied based on medical necessity, and if the conditions are met for an expedited appeal, Molina will automatically initiate an expedited appeal on behalf of the Member.**

## Time Limitations

Processing of complaints and appeals for Members must be completed within thirty (30) calendar days from the date a written or verbal complaint or appeal request is received. If a delay is incurred, the Member will be notified prior to the thirtieth ($30^{th}$) day. Molina Healthcare may extend the thirty (30) day timeframe by fourteen (14) calendar days if the Member requests the extension, or it is demonstrated to HSD that there is need for additional information, and the extension is in the Member's best interest.

A formal Member complaint or appeal request must be filed within ninety (90) calendar days of the date of Molina Healthcare's notice of action or the date the dissatisfaction occurred.

## Processing Member Formal Complaints and Appeals

Molina Healthcare provides to the Member and/or his/her representative, the opportunity before and during the appeal process, to examine the case file, including medical records and other documents and records considered during the appeal process that are not considered as confidential or privileged information. Molina Healthcare will include as parties to the complaint or appeal, the Member and his/her representative, or the legal representative of a deceased Member's estate.

- The complaint or appeal will be reviewed by a committee of one or more Molina Healthcare employees, who did not participate in any previous level of review or decision-making, including staff with expertise in the issue(s) under review; and
- When resolved, the Appeals Staff will inform the Member of the outcome of the review by letter. If the Member is dissatisfied with the resolution, he/she may appeal the decision with Molina Healthcare. If dissatisfied with an appeal outcome, the Member may also appeal to HSD. Please note, Molina Healthcare **State Coverage Insurance (SCI**) & **University of New Mexico State Coverage Insurance (UNM SCI)** Members must exhaust the entire Molina Healthcare appeal process before they can appeal to HSD.

# Member and Practitioner/Provider Complaints and Appeals (*continued*)

The written decision will include the following:

- The results of the complaint or appeal review;
- The date the review of the complaint or appeal was completed;
- All information considered in investigating the complaint or appeal;
- Findings and conclusions reached based on the investigation results; and
- Disposition of the complaint or appeal.

If a denial has been upheld in whole or in part, the following information will also be provided:

- Information regarding the fact that the Member may, with a written request, receive reasonable access to and copies of all documents relevant to the appeal as allowed by law;
- Information on the Member's right to request an administrative hearing to appeal the decision to the HSD Hearings Bureau within ninety (90) calendar days of the decision;
- The right to request the continuation of benefits while the hearing is pending, and how to make this request; and
- A statement that the Member may be held liable for the cost of those appealed benefits if the hearing decision upholds Molina Healthcare's original decision/action.

# Member and Practitioner/Provider Complaints and Appeals (*continued*)

## Requesting an External Hearing, Also Known as a Fair Hearing or HSD Administrative Hearing for Members

For Molina Healthcare **SCI** Members and **UNM SCI** Members, the external hearing may be requested **only after** the Molina Healthcare appeal process has been exhausted. Issues of late premium payment or failure to pay the premium addressed through the Molina Healthcare grievance and appeal process and not resolved at that level must next be taken to judicial appeal in the state district court at the appellant's expense.

To file an appeal through HSD, the request should be sent to:

**The New Mexico Human Services Department**
**Administrative Hearings Bureau**
**P.O. Box 2348**
**Santa Fe, NM 87504-2348**
**Santa Fe: (505) 476-6213**
**Toll free: (800) 432-6217, option #6**
**Fax: (505) 476-6215**

When the HSD receives a request for an administrative hearing to appeal Molina Healthcare's final decision, an official record of the appeal and copy of Molina Healthcare's final decision will be submitted to the HSD Hearings Bureau.

## Continuation of Benefits While Awaiting the HSD Administrative Hearing

If the Member's request for an Administrative Hearing is received by HSD within thirteen (13) calendar days of Molina Healthcare's final decision, and all required benefit continuation criteria is met, this action places in suspension Molina Healthcare's decision to discontinue services currently provided, but it does not require Molina Healthcare to initiate any treatment or services or increase the level of any current treatment or service until the expiration of benefit continuation occurs.

Molina Healthcare shall continue the Member's benefits while the appeal and/or HSD Administrative Hearing process is pending if all of the following are met:

- The Member or the practitioner/provider files a timely appeal to HSD of Molina Healthcare's action (within thirteen [13] days of the date Molina Healthcare mails the notice of action);

# Member and Practitioner/Provider Complaints and Appeals (*continued*)

- The appeal involves the termination, suspension, or reduction of previously authorized course of treatment;
- The services were ordered by an authorized practitioner/provider;
- The time period covered by the original authorization has not expired; and
- The Member requests extension of the benefits.

***The Member will be responsible for repayment of services provided to the Member if the Administrative Hearing decision is not in the Member's favor.***

Molina Healthcare shall provide benefits until one of the following occurs:

- The Member withdraws the appeal;
- Thirteen (13) days have passed since the date Molina Healthcare mailed the resolution letter, provided the resolution of the appeal was against the Member and the Member has taken no further action;
- An HSD Administrative Law Judge issues a hearing decision adverse to the Member; and
- The time period of service limits of a previously authorized service has expired.

If the final resolution of the appeal is adverse to the Member, Molina Healthcare may recover the cost of the services furnished to the Member while the appeal was pending to the extent that services were furnished solely because of the benefit continuation requirement.

If Molina Healthcare or an HSD Administrative Law Judge reverses a decision to deny, limit, or delay services, and:

- The Member did not receive the disputed services while the appeal was pending, Molina Healthcare will authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires; and
- If the Member received the disputed services while the appeal was pending.

# Practitioner/Provider Reconsideration Reviews, Complaints and Appeals

In an effort to streamline the practitioner/provider Complaint (also known as a grievance) and Appeal Resolution Process, Molina Healthcare has instituted a new process for handling complaints and appeals resolutions, and reconsideration requests, for our plan. Molina Healthcare requests that practitioners/providers review this section, and become familiar with this process, as well as the Provider Reconsideration Review (PRR) form that is available at the end of this section.

# Member and Practitioner/Provider Complaints and Appeals (*continued*)

If a practitioner/provider has any questions, concerns and/or inquiries about issues related to the payment of claims, we ask that the practitioner/provider or a knowledgeable Member of his/her staff first contact a Member Service Representative (MSR) for assistance. The MSR will attempt to resolve the issue on an informal basis. The MSR will ask for pertinent information (i.e., dates of service, claim number, name of the Molina Healthcare Member involved). Please be ready to provide this information at the time of the call. The MSR will do an initial investigation and contact a Provider Service Representative (PSR). The MSR and/or PSR will then contact the practitioner/provider via verbal, electronic or telephonic communication within two (2) to seven (7) business days regarding the results of the research and what action will be taken along with the rationale for that action. The investigation outcome as well as the notification of such to the practitioner/provider will be documented in Molina Healthcare's call tracking system.

A practitioner/provider with a concern, question, or complaint should contact a MSR or his/her PSR. In instances when the MSR or PSR may not fully appreciate the nature of the practitioner/provider's concerns, or if the practitioner/provider is dissatisfied with the results of the initial inquiry, he/she may contact the Network Management and Operations (NM&O) department in **Albuquerque at (505) 342-4660 or toll free at (800) 377-9594**. The practitioner/provider also has the option of filing a practitioner/provider reconsideration review (PRR) request for payment issues.

If a practitioner/provider is dissatisfied with the outcome of the initial inquiry investigation that results in claims continuing to be denied or only partially allowed, a PRR should be submitted within one hundred eighty (180) calendar days of Molina Healthcare's notice of action. A copy of the PRR form can be found at the end of this section. The request is generally resolved within thirty (30) calendar days upon receipt of all required documentation such as:

- A copy of the original claim;
- A copy of the claim Explanation of Benefit (EOB)/Remittance Advice (RA); and
- A copy of all pertinent information such as, denial letter, supporting medical records, and any new information pertinent to the PRR request.

Any request for a PRR submitted without this documentation may be delayed. PRR requests submitted more than one hundred eighty (180) calendar days from Molina Healthcare's notice of action may be denied.

The NM&O department receives and reviews the PRR requests. PRR requests submitted without proper documentation may result in delays. The practitioner/provider will be notified in writing within thirty (30) days of specific information missing and required for the review process, which is tracked by the NM&O department. The practitioner/provider has thirty (30) calendar days to submit additional information or the request will be closed.

# Member and Practitioner/Provider Complaints and Appeals (*continued*)

When all required information has been collected, the NM&O department will review and document the findings in call tracking. If additional research is required to fully investigate the case, the NM&O department will coordinate with the appropriate internal department or external resources.

If the review determines that the request is unsupported, the practitioner/provider will be notified in writing of the review decision by the NM&O department, within thirty (30) calendar days of receipt of the completed PRR form and all required documentation necessary for review. Practitioners/providers are reminded that they may NOT direct bill a Member when a denial for covered services is upheld per review.

## Practitioner/Provider Payment or Utilization Management (UM) Formal Appeals

Practitioners/providers who are not satisfied with the PRR outcome may request a formal appeal review. Those items eligible for formal appeal review include payment (e.g., denied claims, partially allowed claims, late filing of claims) and UM issues (e.g., denials resulting from not obtaining prior authorization for some or all types of services and/or for all dates of service).

A request for a formal appeal review must be submitted within ninety (90) calendar days of the PRR determination or the original Molina Healthcare notice of action. Practitioners/providers failing to submit a formal appeal request within the required timeframe waive his/her right to formal appeal review.

The practitioner/provider will be notified of the formal appeal review outcome in writing within thirty (30) calendar days from receipt of the formal appeal request, unless an extension is requested.

## Practitioner/Provider Reconsideration Internal Hearings

Should the practitioner/provider remain dissatisfied with the outcome of a formal appeal review, a second (2nd) level of appeal review is available in the form of a Provider Reconsideration Hearing (PRH). A practitioner/provider has thirty (30) calendar days from the first (1st) level appeal review determination to request a PRH review. Practitioner/providers failing to submit a request for a PRH review within the required timeframe waive his/her right to further review. When a practitioner/provider requests a PRH review for a payment or UM issue, Molina Healthcare reviews the additional information/documentation for indications that the case can be settled without a formal hearing. If the case cannot be settled on an informal level, Molina Healthcare sends a letter of acknowledgment to the practitioner/provider.

Molina Healthcare will schedule and hold the hearing and a decision will be made within thirty (30) days from the date of receipt of the request unless an extension is requested by either the practitioner/provider or the health plan. The practitioner/provider will be notified in writing or verbally of the hearing date and time.

# Member and Practitioner/Provider Complaints and Appeals (*continued*)

Practitioner/Provider reconsideration hearings will not be held for issues other than for payment or UM related issues. In addition, practitioner/provider reconsideration hearings will not be held for services denied for lack of medical necessity or for issues where no new or additional relevant information is submitted aside from what was submitted for the appeal review.

Situations such as when a practitioner/provider states that a Molina Healthcare Representative or Member was rude are not considered issues for the Reconsideration Hearing process. Follow-up and possible corrective actions may be taken; however, no adverse determination decision could be appealed.

The practitioner/provider can choose to have the Reconsideration Hearing Committee (Committee) perform the review based on the written information submitted, or the practitioner/provider may appear in person or telephonically to present his/her appeal to the Committee. The hearing will be held regardless of whether or not the practitioner/provider attends.

The Committee's decision is final and will not be subject to further internal review. No practitioner/provider shall be subject to retaliatory action by Molina Healthcare for filing a complaint/grievance or appeal.

## Claim Corrections/Resubmissions

The resubmission of a corrected claim(s) or submission of requested information does not qualify as a PRR, formal complaint or appeal. All claim correction/resubmissions MUST be submitted to Molina Healthcare Claims Department as new claim submissions. Please do not submit your corrections as an "appeal" as this will only result in a delay of your request.

Claim correction/resubmission requests must be submitted within the required timeframes of the original remittance advice (RA) in order to be considered. Items being resubmitted **must be** clearly marked as a correction/resubmission, along with supporting documentation (i.e., the previous claim and RA, a copy of the referral/authorization if applicable) and/or information explaining the correction/resubmission. Failure to submit corrected claims in the proper format will result in the claim being denied.

In the case of an overpayment or recoupment of money, a letter requesting the refund will be mailed to the practitioner/provider. The practitioner/provider has sixty (60) days to submit the refund before the amount is deducted from the practitioner/provider RA.

# Member and Practitioner/Provider Complaints and Appeals (*continued*)

## Opening a Practitioner/Provider Complaint

A practitioner/provider complaint (also known as a grievance) may be submitted in the following situations:

- The operation of the plan, including concerns regarding quality of and access to health care services, the choice of health care practitioner/provider and the adequacy of the practitioner/provider network;
- The existence of adequate cause to terminate a practitioner's/provider's participation with Molina Healthcare to the extent that the relationship is terminated for cause; or
- Other terminations of a practitioner's/provider's relationship with Molina Healthcare.

Practitioners/providers may generate a complaint by calling the Molina Healthcare Member Services Department during regular business hours to request the PRR form.

**Albuquerque: (505) 341-7493**
**Toll free: (888) 825-9266**

Written complaints must be submitted by mail or fax to:

**Molina Healthcare of New Mexico, Inc.**
**Attn: Appeals Department**
**P.O. Box 3887**
**Albuquerque, NM 87190-9859**
**Fax: (505) 342-0583**

## Reporting of Practitioner/Provider Complaints and Appeals

Practitioner/provider complaints and appeals are reported to Molina Healthcare's governing body, the Board of Directors, through the Member and Provider Satisfaction Committee (MPSC) on a semi-annual basis. Complaint and appeal data is reported to HSD/MAD.

Records of all complaint and/or appeal issues and related documentation will be maintained on file a minimum of ten (10) years.

# Member and Practitioner/Provider Complaints and Appeals (*continued*)

## Practitioner/Provider Internal Fair Hearing - Terminations Based on Cause

The fair hearing process is available to practitioners/providers when disputing whether Molina Healthcare has adequate cause to terminate his/her participation with Molina Healthcare. The practitioner/provider is notified in writing thirty (30) calendar days prior to the proposed termination except when the quality of care provided to patients is the basis of Molina Healthcare's proposed termination. In such situations, the termination and notification will be immediate.

A certified letter of the proposed termination will be mailed with an explanation for the proposed termination, and the practitioner/provider's right to appeal the proposed termination by requesting a fair hearing.

The fair hearing request from the practitioner/provider must be in writing and received within 30 calendar days following receipt of the notification letter. Failure to submit such a request within 30 calendar days constitutes a waiver of any right to appeal.

If the practitioner/provider requests a fair hearing, the Chief Medical Officer will schedule and arrange for the fair hearing. The date of commencement of the fair hearing shall not be less than thirty (30) calendar days from the notification letter, no more than sixty (60) calendar days from the date of receipt of the request for the fair hearing from the practitioner/provider. The Chief Medical Officer will select the individuals to serve on the Hearing Committee. The Hearing Committee will consist of at least three (3) but no more than five (5) practitioners/providers, and will include whenever feasible at least one (1) individual practicing in the same specialty as the affected practitioner(s)/provider(s). The decision of the Hearing Committee will be final and not subject to further internal fair hearings. At a Practitioner/Provider fair hearing, a practitioner/provider has the right to:

- Attend the fair hearing;
- If the practitioner/provider cannot appear in person at the hearing, the practitioner/provider will be given the opportunity to communicate with the board by conference call;
- Present his/her case to the fair hearing board;
- Submit supporting material both before and at the hearing;
- Ask questions of any representative of Molina Healthcare who attends the hearing;
- Be represented by an attorney or by any other person of the practitioner/provider's choice (at the practitioner/provider's expense); and
- Receive an expedited fair hearing in those instances where Molina Healthcare has not provided advance written notice of termination to the practitioner/provider because Molina Healthcare has a good faith and reasonable belief that further care by the practitioner/provider could result in imminent and significant harm to a Member.

Within thirty (30) calendar days of the conclusion of the fair hearing, the Hearing Committee will provide a written decision and report. The decision of the Hearing Committee will be made by majority vote. Upon receipt of the Hearing Committee's decision, the Chief Medical Officer will

# Member and Practitioner/Provider Complaints and Appeals (*continued*)

either adopt or reject the Hearing Committee's proposed decision. The Chief Medical Officer's action constitutes the final decision.

Although an external hearing process does not exist for a practitioner/provider, any practitioner or provider who is dissatisfied with the result of a Complaint, Appeal or fair hearing review decision may contact the Superintendent of Insurance at the address below.

**Superintendent of Insurance**
**Attn: Managed Health Care Bureau**
**New Mexico Public Regulation Commission**
**P.O. Box 1269**
**1120 Paseo de Peralta**
**Santa Fe, NM 87504-1269**
**Santa Fe: (505) 827-4428**
**Fax: (505) 837-4734**
**Email: mhcb.grievance@state.nm.us**

# Definitions

**ACTION:** Any action by Molina Healthcare, defined as 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 a service, failure to provide services in a timely manner, or failure to complete an authorization request in a timely manner.

**ADVERSE DETERMINATION:** A decision by Molina Healthcare that a health care service requested by a practitioner/provider or Member; 1) has been reviewed and based upon the information available does not meet Molina Healthcare requirements for covered services; and 2) coverage for the requested health care service is therefore modified, denied, reduced, or terminated.

**APPEAL:** A request for a review of a Molina Healthcare action.

**AUTOMATIC APPEAL:** Molina Healthcare files an automatic appeal for the Member when Molina Healthcare makes a decision to deny or limit an expedited service request from a practitioner/provider.

**CLAIM CORRECTION/ADJUSTMENT:** When a practitioner/provider submits information for a previously submitted claim or when a practitioner/provider requests adjustment of an already processed claim for any reason. These types of issues are not appeals and should not be labeled as such.

**COVERED MEMBER:** A covered Member is a policyholder, subscriber, enrollee, or other individual entitled to receive health care benefits provided by Molina Healthcare.

**EXPEDITED PRE-SERVICE REVIEW:** The process used for handling a complaint and/or appeal when the normal time frame could seriously jeopardize; 1) the life or health of the Member; 2) the Member's ability to regain maximum function. The Member, an authorized representative of the Member, or the Member's practitioner/provider, may request an expedited review of an Adverse Determination by Molina Healthcare. The decision regarding all expedited reviews are made within seventy-two (72) hours from receipt of the Member's request. (See "Automatic Appeal" definition).

**HUMAN SERVICES DEPARTMENT (HSD):** The executive department in the State of New Mexico that is responsible for the administration of Title XIX (Medicaid). The term HSD may also indicate the Department's designee, as applicable.

# Definitions (*continued*)

**INFORMAL COMPLAINT:** An oral or written expression of dissatisfaction that can be resolved to the Member's and/or practitioner/provider's satisfaction without advancing to a formal complaint and/or appeal.

**IN-PLAN PRACTITIONER/PROVIDER:** A practitioner/provider who has entered into an agreement with Molina Healthcare to provide covered services to Members.

**MANAGED HEALTH CARE PLAN:** Health care insurer or a practitioner/provider service network offering a benefit that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care practitioners/providers managed, owned, under contract with or employed by the health care insurer or practitioner/provider service network. "Managed health care plan" or "plan" does not include a health care insurer or practitioner/provider service network offering a traditional fee-for service indemnity benefit or a benefit that covers only short-term travel, accident-only, limited benefit, student health plan or specific disease policies.

**MEMBER COMPLAINT: Also known as a "grievance".** A written or oral expression by a Member or his/her designee, of dissatisfaction regarding any aspect of Molina Healthcare, other than a Molina Healthcare action.

**MEMBER RECONSIDERATION REVIEW:** An internal review committee that reviews a Member's case with the Member and/or his/her representative in person when the Member disagrees with an internal review decision, action or inaction by Molina Healthcare.

**POST-SERVICE REVIEW:** A request to change a Molina Healthcare action for care or services that have already been received by the Member. This applies to coverage decisions only.

**PRACTITIONER:** An individual, such as a physician or other qualified practitioner, who provides primary care services (including family practice, general practice, internal medicine & pediatrics), and manages routine health care needs.

**PRACTITIONER/PROVIDER COMPLAINT:** Also called a "grievance." A Complaint is a concern that a practitioner/provider may have regarding:

- The operation of Molina Healthcare, including concerns regarding quality of and access to health care services, the choice of health care practitioner/provider and the adequacy of the practitioner/provider network; or
- The existence of adequate cause to terminate a practitioner's/provider's participation with Molina Healthcare to the extent that the relationship is terminated for cause.

**PRACTITIONER/PROVIDER FAIR HEARING:** Final internal appeal process afforded to practitioners/providers appealing Molina Healthcare's decision to discontinue, for-cause, a practitioner/provider's employment, contractual relationship, or other business relationship with Molina Healthcare.

# Definitions (*continued*)

**PRACTITIONER/PROVIDER GRIEVANCE: Also known as a "complaint."** A concern that a practitioner/provider may have regarding:

- The operation of the health care plan, including concerns regarding quality of and access to health care services, the choice of health care practitioners/providers and the adequacy of the practitioner/provider network; or
- The existence of adequate cause to terminate a practitioner's/provider's participation with the health care plan to the extent that the relationship is terminated for cause.

**PRACTITIONER/PROVIDER PAYMENT ISSUES:** Such issues as denied claims or partially paid claims. A practitioner/provider submits a practitioner/provider Reconsideration Review Request (PRR) along with supporting documentation to Molina Healthcare for additional claim review.

**PRACTITIONER/PROVIDER RECONSIDERATION HEARING:** An internal review committee that reviews a practitioner's/provider's case when the practitioner/provider disagrees with an action or inaction by Molina Healthcare. The practitioner/provider and/or his/her representative may appear in person at this hearing. If that is not practical, the practitioner/provider or representative may attend the hearing telephonically, if desired.

**PRACTITIONER/PROVIDER RECONSIDERATION REVIEW REQUEST:** Please see a sample copy at the end of this section. This form is to be utilized when requesting any review of denied or partially paid claims.

**PRACTITIONER/PROVIDER TERMINATION:** The discontinuation of a practitioner/provider employment, contractual relationship, or other business relationship with Molina Healthcare that is instituted by Molina Healthcare and is involuntary on the part of the practitioner/provider.

**PRE-SERVICE APPEAL:** A written or oral review request submitted by, or on behalf of, a Member to change a Molina Healthcare action for care or service that Molina Healthcare must approve, in whole or in part, in advance of the Member obtaining care or services.

**PRIMARY CARE PRACTITIONER (PCP):** An individual, such as a physician or other qualified practitioner, who provides primary care services and manages routine health care.

**PROVIDER:** An institution or organization that provides services for Members. Examples of providers include hospitals and home health agencies.

**UTILIZATION MANAGEMENT (UM) REVIEW:** The review and evaluation of the clinical necessity, appropriateness, efficacy, and efficiency of health care services and settings.