APPEALS AND GRIEVANCES

Appeals, Grievances, and State Hearings
Molina Healthcare maintains an organized and thorough grievance and appeal process to ensure timely, fair, unbiased, and appropriate resolutions. Molina Healthcare members, or their authorized representatives, have the right to voice a grievance or submit an appeal through a formal process.

Molina Healthcare ensures that members have access to the appeal process, by providing assistance throughout the whole procedure in a culturally and linguistically appropriate manner; including oral, written, and language assistance if needed. Grievance information is also included in the Member Handbook.

This section addresses the identification, review, and resolution of member grievances and appeals.

MEMBER APPEALS AND GRIEVANCES
The Ohio Administrative Code defines a grievance (complaint) as an expression of dissatisfaction with any aspect of Molina Healthcare or participating providers’ operations, provision of health care services, activities, or behaviors.

Members may 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 a grievance in writing to:

Molina Healthcare of Ohio, Inc.
Attn: Appeals and Grievance Department/MIRR
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. An authorized Representative Form can be found on Molina Healthcare’s member website.

Molina Healthcare will investigate, resolve and notify the member or representative of the findings. Every attempt will be made to resolve a grievance at the time of a call. However, if a grievance is unable to be resolved immediately, it will be resolved as expeditiously as possible, but no later than the following timeframes:
• Two (2) working days of receipt of a grievance related to accessing medically necessary Medicaid covered services.
• Thirty (30) calendar days of receipt for grievances that are not claims related.
• Sixty (60) calendar days for grievances regarding bills or claims.

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 his/her 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.

An appeal is the request for a review of an action. The member or his/her representative acting on the member’s behalf has the right to appeal Molina Healthcare’s decision to deny a service. For member appeals, Molina must have written consent from the member authorizing someone else to represent him/her. A determination will not be made if written consent is not received within 15 days from the date the appeal was received. An authorized Representative Form can be found on Molina’s member website. An appeal can be filed verbally or in writing within 90 days from the date of the Notice of Action. Molina Healthcare will send a written acknowledgement in response to written appeal requests received. 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 the Ohio Department of Medicaid (ODM)).

While lack of written consent does not pose any barrier to the commencement of the appeal process, if it is not received within the time frame the appeal request will be closed and no determination will be made.

The member or representative should state the reason he/she feels the service should be approved and be prepared to provide any additional information for review. For a copy of the Grievance and Appeal Form, see the “Forms” section of this manual.

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

Expedited member appeals may be requested by the member or representative orally or in writing. Molina Healthcare will inform the member or representative of the decision to treat the appeal as expedited within 24 hours of receipt. With few exceptions, an expedited member appeal will be resolved as expeditiously as the member’s health condition requires but will not exceed 72 hours from receipt and the member or representative will be notified. No punitive action will be taken against a member or representative for filing an expedited member appeal.
If Molina Healthcare denies the request for an expedited resolution of an appeal, the appeal will be treated as a standard appeal and resolved within 15 calendar days from the receipt date (unless an extension was granted).

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.