Section 13. Complaints, Grievance and Appeals Process

Molina Healthcare Members or Member's personal representatives have the right to file a grievance and submit an appeal through a formal process. All grievances and appeals must first be submitted to Molina Healthcare for resolution, but may later be appealed to the Administrative Law Judge. However, the filing of a grievance does not preclude the Member from filing a complaint with Utah Department of Insurance.

This section addresses the identification, review and resolution of Member grievances and appeals. Below are Molina Healthcare's Member Grievance and Appeals Process.

Definitions:

Appeal: An Appeal is a request for Molina Healthcare to review a decision made. Appeals may be made by Members (or Designated Representative) and by Providers.

Clinical Peer: Clinical peer means a health care professional who is in the same profession and the same or similar specialty as the health care provider who typically manages the medical condition, procedures, or treatment under review.

Complaint: The reporting of an issue or concern submitted to Molina Healthcare by or on behalf of a Member regarding any aspect of Molina Healthcare as it relates to the Member that is recorded in Molina's complaint log, and resolved by Molina where the concern is not escalated to the level of a formal grievance.

Expedited Appeal: An Expedited Appeal is a request for Molina Healthcare to review a decision made where the decision is related to one of the following health care services, referrals or procedures:

I. Services for a Member with an ongoing course of treatment where the denial of such services could significantly increase the risk to the Member's health; or where a treatment, service or ;
II. Referral for services or procedures where the denial of request could significantly increase the risk a Member's health

Grievance: Grievance means any written complaint submitted to Molina Healthcare by or on behalf of a Member regarding any aspect of Molina Healthcare relative to the Member, but shall not include any complaint by or on behalf of a provider.

Grievance Committee: Grievance Committee means individuals who have been appointed by Molina Healthcare to respond to grievances which have been filed on appeal from Molina Healthcare's simplified complaint process.

Member Complaints:

Molina Healthcare has a simplified process whereby Members can register complaints which are logged and recorded by Molina. These complaints are resolved without the filing of a formal grievance and without the involvement of the Grievance Committee.

The resolution of a Member complaint does not preclude Member from access to review by the grievance committee of a formal grievance.

Complaints can be made by contacting Molina Healthcare Member Services at: 888-483-0760

Second opinion:

If a Member does not agree with their provider's plan of care, they have the right to a second opinion from another provider. Member can call Member Services to find out how to get a second opinion.

Member Grievance Process:

If a member is unhappy with the service from Molina Healthcare or providers contracted with Molina Healthcare, they may file a grievance by contacting Member Services toll-free at 888-483-0760. They can also write to us at:

Molina Healthcare of Utah, Inc.
Attn: Appeals and Grievance, Complaints Dept.
7050 Union Park Center, Ste. 200
Midvale, UT 84047

Or via fax: 801-858-0409.

All grievances, whether oral or written, are documented and logged by the Member Services Department in all appropriate Systems. Members are notified of their grievance and appeal rights and the different levels of grievances and appeals through various general communications including, but not limited to, the member handbook, Evidence of Coverage and Disclosure, Member Newsletters and Molina Healthcare's website: www.molinahealthcare.com

Members may identify an individual, including an attorney or provider, to serve as a personal representative to act on their behalf at any stage during the grievance and appeals process. If under applicable law, a person has authority to act on behalf of a member in making decisions related to health care or is a legal representative of the member, MHU will treat such person as a personal representative.

The Member (or designated representative) shall have the right to attend and participate in the formal grievance proceedings.

The Member/Personal Representative may file a Grievance within one year (365 days) after the date of occurrence that initiated the grievance.

When needed, Members are given reasonable assistance in completing forms and taking other procedural steps, including translation services for members with limited English proficiency or other limitations, e.g., hearing impaired, requiring communication support.

Members will continue any and all benefits while in the Grievance and Appeals process unless previously disenrolled.

Any issues related to a clinical denial and/or appeal of a coverage decision is referred to the Utilization Management Department to review the medical necessity aspects of the request. Any grievance or appeal with Potential Quality of Clinical Care (PQOC) are referred to the Quality Improvement Department for further investigation and handling Additionally, any identified issue related to the Privacy and Confidentiality of Protected Health Information (PHI) is referred to the Privacy Officer.

MHU has an organized grievance process to ensure thorough, appropriate and timely resolution to members' grievances and to aggregate and trend reasons for grievances in order to take action to reduce future occurrence. All grievances are entered into the Grievance and Appeal Tracking Log by the individual taking the call or receiving the communication. If the individual receiving the communication cannot resolve the issue, the issue is assigned to the appropriate department or individual for resolution. Once the issue is resolved, the call "manager" will close the issue and document the outcome. Once a grievance is received, it will not be closed in the Tracking Log until the member has been notified of the outcome, has had the right to appeal if appropriate and the final disposition documented.

Grievance documentation will include the following factors:

- The substance of the grievance and actions taken
- The investigation of the substance of the grievance, including any aspects of clinical care involved
- The outcome/resolution
- The documentation of notification to the member of the disposition of the grievance and the right to appeal, as appropriate.

Members who are not satisfied with Molina's resolution of any grievance may appeal the decision to the Administrative Law Judge at the following phone number:

877-837-3247

Grievance Timelines:

A written and signed acknowledgement of the grievance is sent to the member within 10 business days of receipt.

A determination will be made by the Grievance Committee within 30 days from the date the grievance is received by Molina Healthcare. The determination by the Grievance Committee

may be extended for not more than 30 days in the event of a delay in obtain the documents or records necessary for the resolution of the grievance.

Molina Healthcare will provide any documentation furnished to the Grievance Committee to the Member at least 5 business days prior to the grievance hearing.

Molina Healthcare will provide the Member (or Designated Representative) written notification of determination of Grievance Committee within 5 business days of determination. Where grievance was final appeal step, Molina will also provide notification of the availability of the (insert agency/department name) to respond to Member inquires.

Appeals:

Appeals may be submitted by Members (or Designated Representative) or by Providers (PCPs or other providers rendering care). Members and Providers are notified of the following at the time they are notified of Molina's decision in connection to a requested healthcare service or claim for service:

- Their right to appeal the decision
- The process by which the appeal process is initiated
- The Molina Healthcare Customer Service phone number where more information regarding the appeal process can be obtained.
- The availability of the Utah State Department of Insurance

An Appeal must be filed within 90 calendar days of receipt of the notice of the Health Plan's action.

Appeals must be written and may be submitted to:

Molina Healthcare of Utah, Inc.

Attn: Appeals and Grievance, Complaints Dept.

7050 Union Park Center, Ste. 200

Midvale, UT 84047

Or

Via Fax: 801-858-0409.

Molina Healthcare will designate a clinical peer to review appeals. No one reviewing an appeal may have had any involvement in the initial determination that is the subject of the appeal.

Written notifications of the appeal decision will contain reasons for the determination, the medical or clinical criteria for the determination.

If the appealing party is dissatisfied with the outcome of an appeal, an External Independent Review may be requested.

Members who are not satisfied with Molina's final resolution of any appeal may further appeal the decision to the Administrative Law Judge at the following number:

877-837-3247

Any issues related to a clinical denial and/or appeal of a coverage decision is referred to the Utilization Management Department to review the medical necessity aspects of the request. Any grievance or appeal with Potential Quality of Clinical Care (PQOC) is referred to the Quality Improvement Department for further investigation and handling. Additionally, any identified issue related to the Privacy and Confidentiality of Protected Health Information (PHI) is referred to the Privacy Officer.

Expedited Appeals Process and Timeline:

Expedited appeals may be submitted in writing to the address or fax number above.

Upon submission of appeal, Molina Healthcare will notify the party filing the appeal as soon as possible, and within no more than 24 hours after receipt, of all information that is required to evaluate the appeal. Molina Healthcare will render a decision within 24 hours of receiving the required information.

Within 24 hours of rendering a decision, Molina Healthcare will notify the party filing the appeal, the Member (or designated representative) the Member's PCP, and any health care provider who recommended the care service involved in the appeal orally of its decision. Oral notification will be followed up by a written notice of determination.

Standard Appeals Process and Timeline:

Standard appeals may be submitted in writing to the address or fax number above.

Upon submission of appeal, Molina Healthcare will notify the party filing the appeal, within 3 business days, of all information that is required to evaluate the appeal. Molina Healthcare will render a decision on the appeal within 15 business day after receipt of the required information.

Molina Healthcare will notify the party filing the appeal, the Member (or designated representative) the Member's PCP, and any health care provider who recommended the care service involved in the appeal orally of its decision. Oral notification will be followed up by a written notice of determination.

If the party filing the appeal is dissatisfied with Molina Healthcare's determination, an External Independent Review or a State Medicaid hearing may be requested.

External Independent Review:

An external independent review may be requested by a Member (or designated representative) or by a provider (PCP or other provider rendering service). The party seeking an external independent review must notify Molina Healthcare of this request in writing at the address above.

Requests for External Independent Review must be submitted within 30 days of receipt of written notification of a denied appeal. Written request must be accompanied by any information or documentation to support the Member's request for covered service or claim for a covered service.

Molina Healthcare will do the following within 30 days of receipt of request for External Independent Review:

- Provide mechanism for the joint selection (involving Molina Healthcare and the Member, Member's Physician, or other health care provider) of an external independent reviewer.
- Forward the selected independent reviewer all medical records and supporting documentation, a description of the applicable issues, and a statement of Molina's decision along with the criteria used and medical and clinical reasons for the decision.

Within 5 days after receiving all of the necessary information, the independent reviewer will evaluate and analyze the case and render a decision. The decision by the independent review is final. If the reviewer determines the health care service to be medically appropriate, Molina will pay for the service.

The independent reviewer will not be informed of the specific identity of the Member.

The independent reviewer must be a clinical peer and have no direct affiliation to Molina or financial interest in connection with the case in question.

Expedited External Independent Review

Molina Healthcare will resolve all external independent review as expeditiously as possible. Molina Healthcare will make a determination and provide written notification of the determination within no more than 24 hours after the receipt of all necessary information when a delay would significantly increase the risk to a Member's health or when extended health care services for a Member undergoing a course of treatment prescribed by a health care provider are at issue.

Review by Administrative Law Judge:

Members not satisfied with the determination of the Independent reviewer may request review by an administrative law judge. Parties to the review include the Plan and the member (or designated representative).

Requests for an administrative law judge review must be filed within 30 days of the date of the initial action that is being reviewed. The request must be sent to the Division of Centralized Docketing at the following address:

Director's Office/Formal Hearings

Division of Medicaid and Health Financing

288 North 1460 West

Salt Lake City, UT 84116-3231

Fax: 801-536-3231

Provider Dispute

The processing, payment or nonpayment of a claim by MHU shall be classified as a Provider Dispute and shall be sent to the following address:

Molina Healthcare of Utah
Attention: Provider Disputes
7050 Union Park Center, Ste. 200
Midvale, UT 84047

Reporting

All Grievance/Appeal data, including practitioner specific data, is reported quarterly to Member/Provider Satisfaction Committee by the Department Managers for review and recommendation. A Summary of the results is reported to the Executive Quality Improvement Committee (EQIC) quarterly. Annually, a quantitative/qualitative report will be compiled and presented to the Member/Provider Satisfaction Committee (MPSC) and EQIC by the chairman of MPSC to be included in the organization's Grand Analysis of customer satisfaction and assess opportunities for improvement.

Appeals and Grievances will be reported to the State quarterly. Grievance and Appeals reports will be reviewed monthly by the Credentialing Coordinator for inclusion in the trending of ongoing sanctions, complaints and quality issues.

Record Retention

MHU will maintain all grievance and related appeal documentation on file for a minimum of six (6) years. In addition to the information documented electronically via Call Tracking in QNXT or maintained in other electronic files, MHU will retain copies of any written documentation submitted by the provider pertaining to the grievance/appeal process. Provider shall maintain records for a period not less than ten (10) years from the termination of the Model Contract and retained further if the records are under review or audit until the review or audit is complete.

(Provider shall request and obtain Health Plan's prior approval for the disposition of records if Agreement is continuous.)