Provider Grievances

1. Provider Grievances are submitted orally or in writing.

2. **A provider may file a grievance**. A provider may present their concerns regarding the operation of the plan, termination from the plan, timeliness of credentialing decisions, concerns regarding quality of and access to health care services, the choice of health care providers and the adequacy of the Molina Healthcare network to the Molina Healthcare Provider Grievance Committee responsible for the substantive area addressed by the concern

3. **Molina Healthcare's Provider Grievance Committee**. Provider concerns will be addressed by a committee of Molina staff members. The Provider Grievance Committee will consist of:
   - Chairperson;
   - Supervisor/Manager/Director of Network Management;
   - Supervisor/Manager/Director of Provider Appeals and Grievances;
   - Supervisor/Manager/Director of Quality Improvement;
   - Supervisor/Manager/Director of Health Care Services; and
   - Medical Director or Chief Medical Officer (acting in the capacity of a consultant if the concern involves a clinical or quality of care issue) – ad hoc member.

4. The decision of the Provider Grievance Committee will be communicated to the provider, in writing within twenty (20) days after the committee has obtained all of the information concerning the provider's grievance.

5. A recap of all provider grievances will be provided to Molina Healthcare's governing body as part of the monthly Senior Leadership Team meeting agenda.

6. Information regarding provider grievance procedures is included in provider contracts, the Provider Manual and remittance advice statements.

7. Registering and responding to provider grievances is done by a member of the Provider Appeals and Grievances Department. The activities involved in registering and responding to provider grievances or appeals includes the following:
   - Documentation of the issue and resolution in the QNXT system;
   - Documentation of the issue and resolution in the Appeals and Grievances (AnG) database;
   - Coordinating provider grievance reviews with the Molina Healthcare Provider Grievance Committee; and,
   - Notification to the provider of the grievance review results in writing within twenty (20) days of receipt of all information concerning the grievance.

8. The Provider Appeals and Grievances Department coordinates relaying provider grievance information to internal quality improvement committees.

9. Written notifications to the provider of grievance review determination decisions will include the following elements:
   - The names and titles of the reviewers;
   - A statement of the reviewer's understanding of the nature of the grievance and all pertinent facts;

- Reference to the evidence or documentation considered by the reviewer(s) in making the decision as applicable; and
- An explanation of the rationale for the reviewer's decision.

10. Molina Healthcare will provide a written explanation to the provider for any proposed termination, and shall deliver reasonable advance written notice to the provider prior to the proposed effective date of the termination. Such notice shall be delivered if the termination is for cause as described in 13.10.16.9 NMAC, Subsection A, if the termination is at the convenience of Molina Healthcare, if the termination is by virtue of a fixed termination date in the provider contract or if Molina Healthcare does not intend to offer renewal of the provider contract.

11. Reasonable advance written notice is a minimum of thirty (30) days, except when the quality of care provided to enrollees is the basis for the termination.

12. When the quality of care provided to enrollees is the basis for the termination and Molina Healthcare has a good faith and reasonable belief that further care by the provider would result in imminent and significant harm to enrollees, Molina Healthcare is not required to provide advance written notice, but shall follow the expedited fair hearing process pursuant to 13.10.16.9(A)(1)(c) NMAC.

13. Molina Healthcare has developed, adopted and implemented a fair hearing process so that a provider may dispute whether Molina Healthcare has adequate cause to terminate a provider's participation with the plan if the provider's relationship with Molina Healthcare is, in fact, being terminated for cause. A provider may present their case to the Provider Grievance Committee which consists of various Molina Healthcare staff Members (see item #3).

14. A provider who is being terminated for cause will be afforded access to the Molina Healthcare fair hearing process. Through this process, the provider will have the following rights:
    - The right to appear in person before the fair hearing committee appointed by Molina Healthcare pursuant to 13.10.16.9(A)(1)(a) NMAC prior to the proposed termination date;
    - The right to present his or her case to the fair hearing committee;
    - The right to submit supporting material both before and at the fair hearing;
    - The right to ask questions of any representative of Molina Healthcare who attends the hearing;
    - The right to be represented by an attorney or by any other person of the provider's choosing; and
    - The right to an expedited hearing in those instances where Molina Healthcare has not provided advance written notice of termination to the provider because Molina Healthcare has a good faith and reasonable belief that further care by the provider would result in imminent and significant harm to enrollees.

15. A written fair hearing decision will be issued to the provider within twenty (20) days after the fair hearing. Following an expedited hearing, a written decision will be forwarded to the provider as soon as the decision is issued, but no later than three (3) business days.

To file a complaint with the New Mexico Office of Superintendent of Insurance (OSI)

To file a complaint with the OSI, use the form found on the OSI website at https://www.osi.state.nm.us/. For grievances concerning Molina Healthcare's operations or provider terminations, follow the procedure for 13.10.16.10 NMAC.

For grievances concerning credentialing and payment dispute resolution, follow the procedures for 13.10.28.13(B) NMAC.

Provider Credentialing Grievances

The purpose of this section is to ensure that providers receive prompt payment from Molina Healthcare for clean claims and interest on unpaid claims.

Molina Healthcare has established a process for resolving payment-related credentialing disputes:

- The provider must contact Molina Healthcare in writing to determine the status of a claim, to ensure that sufficient documentation supporting the claim has been provided, and to determine whether the claim is considered to be a clean claim.
- Molina Healthcare will respond in writing to a provider's inquiry regarding the status of an unpaid claim within 15 days of receiving the inquiry.
- Molina Healthcare's response will explain its failure or refusal to pay, and the expected date of payment if payment is pending.

After Approval of Credentialing

1. The practitioner's contract effective date will be determined by NM&O. Contracted providers will receive a contract effective date no sooner than the beginning of the first of the month following approval by the credentialing committee. Based on access and availability needs, the contract may have an effective date either immediately upon approval of credentialing; or
2. The Associate Vice President/Director of NM&O will determine if the effective date of the contract is to be prior to the Credentialing Committee approval date.

If Network Participation due to Credentialing is Denied

The Credentialing Committee may determine that the practitioner should not be approved for participation in the Molina network. The Credentialing Committee may then vote to deny the practitioner. The practitioner will not be reported to the NPDB and will not be given the right to a fair hearing. Within ten (10) days of the Committee's decision, the practitioner is sent a written notice of denial via certified mail, from the Medical Director, which includes the reason for the denial.

1. For providers denied credentialing approval, payment will revert to out-of-network usual, customary, and reasonable rate effective to the date of denial except as otherwise provided by law; and
2. Services rendered after the denial date, with the exception of emergency situations, will require prior authorization from the Health Care Services (HCS) Department and will be based on access and availability needs.

Non-Participating Providers

- The Network Management and Operations Department is responsible for recruiting and obtaining an executed Provider or Hospital Services Agreement and other appropriate documentation in order to configure the financial terms within Molina Healthcare's systems.
- For providers who will not execute a Molina Healthcare Provider or Hospital Agreement, a standard non-participating contract may be configured within the claims system for reimbursement at the usual, customary, and reasonable rate or specific reimbursement terms may be negotiated on a case-by-case basis and configured accordingly.

Addendum A - State Specific Reimbursement Requirements, Claims Payment, and Interest Calculations

Reimbursement by Molina upon delay in credentialing process (Pursuant to NMAC 13.10.28.12)

Terms for reimbursement - Molina shall reimburse a provider, subject to co-payments, co-insurance, deductibles, or other cost-sharing provisions, for any clean claims for covered services, provided that:

- the date of service is more than forty-five (45) days after the date the provider requested credentialing from Molina and either the provider supplied a completed uniform credentialing application or made the completed uniform credentialing application available for electronic access by Molina, including submission of any supporting documentation that Molina requested in writing during the initial ten (10) day review period;
- Molina has approved, or has failed to approve or deny the applicant's completed uniform credentialing application within the timeframe established pursuant to Subsection C of 13.10.28.11 NMAC;
- the provider has no past or current license sanctions or limitations, as reported by the New Mexico medical board or another pertinent licensing and regulatory agency, or by a similar out-of-state licensing and regulatory entity for a provider licensed in another state; and
- the provider has professional liability insurance or is covered under the Medical Malpractice Act.

Sole practitioner - A provider who, at the time services were rendered has been approved by Molina for credentialing or who has been awaiting a credentialing decision pursuant to Subsection C of 13.10.28.11 NMAC and was not in a practice or group that has contracted with Molina to provide services at specified rates of reimbursement, shall be paid by Molina in accordance with the carrier's standard reimbursement rate or at an agreed upon rate.

Provider group reimbursement - A provider who, at the time services were rendered, has been approved by Molina Healthcare for credentialing or who has been awaiting a credentialing decision pursuant to Subsection C of 13.10.28.11 NMAC and was in a provider group that has contracted with Molina to provide services at specified rates of reimbursement, shall be paid by Molina Healthcare in accordance with the terms of the provider group contract.

Reimbursement period - Molina Healthcare shall reimburse a provider pursuant to Subsections A, B, and C of 13.10.28.12 NMAC until the earlier of the following occurs:

- Molina denies the provider's credentialing application;
- Molina approves the provider's credentialing application and the provider and Molina Healthcare enter a contract to replace a previously agreed upon rate, or
- the passage of three years from the date the insurer received the provider's completed uniform credentialing application.

Payments of Claims, Overdue Claims and Calculation of Interest (Pursuant to NMAC 13.10.28.9)

Pending claims

- Questionable liability and special treatment claims.
    - If, upon receipt of a claim, Molina Healthcare is unable to determine liability for, or otherwise refuses to pay a claim or a portion of a claim of an eligible provider within the time specified in Subsection A of 13.10.28.9 NMAC, Molina shall make a good faith effort to notify the eligible provider electronically, in writing, or by another method, as agreed between Molina and provider, within 30 days of the date of receipt of the claim if

submitted electronically and within forty-five (45) days of the date of receipt of the claim if submitted manually.
    - If, upon receipt of a claim, Molina Healthcare determines that a claim or a portion of a claim requires special treatment due to particular or unusual circumstances that will delay payment beyond the time specified in Subsection A of 13.10.28.9 NMAC, Molina shall make a good faith effort to notify the eligible provider electronically, in writing, or by another method, as agreed between Molina and provider, within thirty (30) days of the date of receipt of the claim if submitted electronically and within forty-five (45) days of the date of receipt of the claim if submitted manually.
- Notification of pending claims. The notification required by Subsection C of 13.10.28.9 NMAC, shall:
    - specify the reason(s) why Molina is refusing to pay the claim, has determined it is not liable for the claim, or shall specify what information is required to determine liability for the claim;
    - clearly indicate if only certain charges associated with a claim are contested; and
    - be repeated by Molina at least monthly until the matter is resolved.
- Uncontested portion of pending claims. The timely payment requirement described in Section A of 13.10.28.9 NMAC applies to any uncontested portion of a contested claim.
- Liability resolved. The date on which liability or special treatment issues are resolved for a pending claim is the date that the claim becomes a clean claim and shall initiate the timely payment requirement described in Subsection A of 13.10.28.9 NMAC.

Overdue payments, calculation of interest

- When payment is not made by Molina to the provider within the time specified in Subsection A of 13.10.28.9 NMAC and there is no question of liability or special treatment as described in Subsection C of 13.10.28.9 NMAC or questions of liability or special treatment have been resolved, interest shall be calculated and paid to the provider, on the unpaid portion of the claim as follows:
    - For any full or partial month, beginning on the 31st day after the claim has been submitted electronically and on the 46th day for claims submitted manually, Molina shall calculate and pay interest in the amount of one and one-half percent for each full or partial month. For purposes of this section, any thirty (30) day period is the equivalent of one month, excepting that a calendar year shall only be equal to twelve (12) months; and
    - Interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. Molina shall not be required to pay any interest calculated to be less than two dollars ($2.00). The interest shall be paid within thirty (30) days of the payment of the claim. Interest can be paid on the same check or electronic transfer as the claim payment or on a separate check or electronic transfer. If Molina combines interest payments for more than one late clean claim, the check or electronic transfer shall include information identifying each claim covered by the check or electronic transfer and the specific amount of interest being paid for each claim.
- When a claim that involves a question of liability or special treatment is ultimately resolved in favor of the provider and is not paid within thirty (30) or forty-five (45) days of becoming an electronic or manual clean claim, respectively, Molina shall pay all of the interest due on the unpaid claim, to be calculated as described in Paragraph (1) of Subsection D of 13.10.28.9 NMAC.