

Section 13. Complaints, and Appeals Process

Provider Claims Reconsideration Dispute

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

**Molina Healthcare of Texas
Attention: Provider Claims Disputes
15115 Park Row Blvd., Suite 110
Houston, TX 77084**

Reporting

All Complaints/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 Complaints will be reported to the State quarterly. Complaints 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

Molina Healthcare of Texas will maintain all complaints 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, Molina Healthcare of Texas will retain copies of any written documentation submitted by the provider pertaining to the complaints/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.)

Complaints and Appeals

Definitions

Complainant (1) means a Member or a treating provider or other individual designated to act on behalf of the Member who filed the Complaint. (2) A Provider who has filed a complaint

Member Appeal is a formal process by which a Member or his/her representative requests a review of the MHT's Action.

Member Inquiry is a request for information that is resolved promptly by providing the appropriate information; or a misunderstanding that is cleared up to the satisfaction of the Member.

Provider Complaint means an expression of dissatisfaction expressed by a provider, orally or in writing to the MHT, about any matter related to the MHT other than a determination of medical necessity for a service. A provider complaint does not include a matter of misunderstanding or misinformation that can be promptly resolved by clearing up the misunderstanding, or providing accurate information to the provider's satisfaction.

Provider Inquiry is a request for information that is resolved promptly by providing the appropriate information; a misunderstanding that is cleared up to the satisfaction of the Provider.

***Provider Claims Reconsideration** is a dispute or request from a provider to review a claim denial or partial payment. Claim reconsideration includes, but is not limited to, timely filing, contractual payment issues etc.

Provider Claims Appeal is a written request for review of a claim denial or partial payment. All claim appeals must be clearly identified as "Provider Claims Appeal" by written request and be accompanied with all necessary documentation which may include but is not limited to, medical records or if claim was previously reviewed through the reconsideration process.

*Molina would encourage providers to submit claims reconsideration prior to submitting a formal written claims appeal.

Provider Appeals

Appeal Process

Appeal means the formal process by which a Provider requests a review of the MHT'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 MHT to act within the timeframes set forth in the contract;

How to file an appeal:

- An appeal must be submitted in writing to:

MOLINA
Write to: Molina Health Care of Texas Attention: Appeals Dept. 15115 Park Row Blvd., Suite 110 Houston, TX 77084

Appeal Timeframes:

- The provider or practitioner is allowed **120 days** from the date of the initial denial notification to submit a first level appeal.
- Provider or Practitioner appeal of a Utilization Management (UM) decision shall be adjudicated in a thorough, appropriate, and timely manner
- A first level appeal for decisions made by Molina Utilization Management 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 a Molina Healthcare Medical Director or an independent reviewer for reconsideration.

Provider Complaints

A provider has the right to file a complaint with Molina Healthcare at any time. The provider also has the right to file a complaint directly with Texas Department of Insurance (TDI).

How to file a Complaint:

- A complaint can be oral or written:

MOLINA	TDI
Call: 1-888-560-2025	Call: 1-800-252-3439
Write to: Molina Health Care of Texas Attention: Complaints Dept. 15115 Park Row Blvd., Suite 110 Houston, TX 77084	Write to: TDI Consumer Protection (111-1A) Po Box 149091 Austin, Texas 78714-9091

Complaint Timeframes:

- A provider can file a complaint anytime.
- 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.

