Section 12. Complaints, Grievance and Appeals Process

What is a Complaint?
A complaint is any dissatisfaction that you have with Molina or any Participating Provider that is not related to the denial of healthcare services. For example you may be dissatisfied with the hours of availability of your doctor. A complaint does not include issues relating to the denial of healthcare services. Issues relating to the denial of health care services are Appeals, and should be filed with Molina or the Ohio Department of Insurance in the manner described in the Internal Appeals section below.

What if I Have a Complaint?
If you have a complaint you can call the following toll-free numbers for assistance:

- Molina at 1 (888) 296-7677, Monday through Friday, 7:00 a.m. - 7:00 p.m. EST.
- If you are deaf or hard of hearing You can call the TTY line at 1 (800) 750-0750 or You can also contact us by calling the National Relay Service at 711.
- You may also contact Molina through Our website www.molinahealthcare.com or by writing a letter. Our address is:
  Molina Healthcare of Ohio, Inc.
  Grievance and Appeals Unit
  P.O. Box 349020
  Columbus, OH 43234-9020

- **You may also contact the Ohio Department of Insurance**
  Ohio Department of Insurance
  ATTN: Consumer Affairs
  50 West Town Street, Suite 300, Columbus, OH 43215
  800-686-1526 / 614-644-2673
  614-644-3744 (fax)
  614-644-3745 (TDD)

  Contact ODI Consumer Affairs:
  https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp

  File a Consumer Complaint:
  http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

Molina recognizes the fact that you may not always be satisfied with the care and services provided by our contracted doctors, hospitals and other providers. We want to know about your concerns and any complaints you may have. You may file a complaint in writing or by calling us. We will respond to your complaint no later than 60-days from when we receive it.

Claims Decisions, Internal Appeals, and External Review

Definitions
For the purposes of this section:
(1) To deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:

(a) A determination that the health care service does not meet Molina's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, including Experimental or Investigational treatments;
(b) A determination that a health care service is not a Covered Service;
(c) The imposition of an exclusion source of injury, network, or any other limitation on benefits that would otherwise be covered.
(2) Not to issue individual health insurance coverage to an applicant, including initial eligibility determinations;
(3) To rescind coverage on a health benefit plan.

"Final Adverse Benefit Determination" means an Adverse Benefit Determination that is upheld after the internal appeal process. If the time period allowed for the internal appeal elapses without a determination by Molina, then the internal appeal will be deemed to be a Final Adverse Benefit Determination.

"Urgent Care Service": means a medical service where the application of non-Urgent Care Service time frames could seriously jeopardize:

- Your life or health or Your unborn child; or
- In the opinion of the treating physician, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Appointing a Representative
If you would like someone to act on your behalf regarding a claim or an appeal of an Adverse Benefit Determination You may appoint an authorized representative. Please send your representative's name, address, and telephone contact information to:

Molina Healthcare of Ohio, Inc.
Grievance and Appeals Unit
P.O. Box 349020
Columbus, OH 43234-9020
1 (888) 296-7677
1 (800) 750-0750 (TTY)

You must pay the cost of anyone you hire to represent or help you.

CLAIMS DECISIONS
After a determination on a claim is made, we will notify you of a favorable determination or Adverse Benefit Determination within a reasonable time, as follows:

Pre-Service Claim

Timeframe for Decision	Timeframe for Notification of Decision
Two business days from receipt of all information reasonably necessary and requested by Molina	Within three business days of decision

Concurrent Service Claim

Timeframe for Decision	Timeframe for Notification of Decision

One business days from receipt of all information reasonably necessary and requested by Molina	Within one business day of decision

Post-Service Claim

Timeframe for Decision	Timeframe for Notification of Decision
30 calendar days from the receipt of all information reasonably necessary and requested by Molina	Within five business days of decision

Urgent Care Service – A claim involving an Urgent Care Service is processed as timely as is possible given the circumstances and will always be processed within no more than 72 hours from receipt of all information reasonably necessary and requested by Molina to make the determination or, if shorter, the period of time required under Section 2719 of the federal Public Health Services Act and subsequent rules and regulations.

Initial Denial Notices

Notice of an Adverse Benefit Determination (including a partial claim denial) will be provided to you by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time frames noted above. With respect to Adverse Benefit Determinations involving an Urgent Care Service, notice may be provided to you orally within the time frames noted above. If oral notice is given, written notification must be provided no later than three days after oral notification.

An Adverse Benefit Determination notice will convey the specific reason for the Adverse Benefit Determination and the specific plan provisions upon which the determination is based. The notice will also include a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary. The notice will disclose if any internal plan rule, protocol or similar criterion was relied upon to deny the claim and a copy of the rule, protocol or similar criterion will be provided to you, free of charge. In addition to the information provided in the notice, you have the right to request the diagnosis and treatment codes and descriptions upon which the determination is based.

The notice will describe Molina's review procedures and the time limits applicable to such procedures following an Adverse Benefit Determination on review.

If an Adverse Benefit Determination is based on Medical Necessity, Experimental or Investigational treatment or similar exclusion or limitation, the notice will provide an explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of the plan to your medical circumstances.

In the case of an Adverse Benefit Determination involving a claim for Urgent Care Service, the notice will provide a description of Molina's expedited review procedures, which are also covered below.

INTERNAL APPEALS

You must appeal an Adverse Benefit Determination within 180 days after receiving written notice of the denial (or partial denial). You may appeal an Adverse Benefit Determination by means of written notice to us, in person, orally, or by mail, postage prepaid.

Your request should include:
− The date of your request.
− Your name (please print or type).
− The date of the service we denied.
− Your identification number, claim number, and provider name as shown on the explanation of health care benefits, which You will automatically receive when we process Your claim.)

You should keep a copy of the request for your records because no part of it can be returned to you.

You may request an expedited internal appeal of an Adverse Benefit Determination involving an Urgent Care Service orally or in writing. In such case, all necessary information will be transmitted between Molina and You by telephone, FAX, or other available similarly expeditious method, to the extent permitted by applicable law.

You may also request an expedited external review of an Adverse Benefit Determination involving an Urgent Care Service at the same time a request is made for an expedited internal appeal of an Adverse Benefit Determination if Your treating physician certifies that the Adverse Benefit Determination involves a medical condition that could seriously jeopardize Your life or health, or would jeopardize Your ability to regain maximum function, if treated after the time frame of an expedited internal appeal (*i.e.*,72-hours). You may not file a request for expedited external review unless you also file an expedited internal appeal.

Determination of appeals of Adverse Benefit Determinations will be conducted promptly, will not defer to the initial determination and will not be made by the person who made the initial Adverse Benefit Determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by You relating to the claim.

On appeal, you may review relevant documents and may submit issues and comments in writing. You may also, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of Molina in connection with the Adverse Benefit Determination being appealed, as permitted under applicable law.

If the Adverse Benefit Determination is based in whole, or in part, upon a medical judgment, including determinations as to whether a particular treatment, drug, or other service is Experimental or Investigational, or not Medically Necessary or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

If new or additional evidence is relied upon or if new or additional rationale is used during the internal appeal process, we will provide to You, free of charge, the evidence or rationale as soon as possible and in advance of the appeals decision in order to provide You a reasonable opportunity to respond.

Time Periods for Decisions on Appeal
Appeals of Adverse Benefit Determinations will be decided and notice of the decision provided as follows:

TIMEFRAME FOR RESPONDING TO APPEAL	
REQUEST TYPES	**TIMEFRAME FOR DECISION**
URGENT CARE SERVICE DECISIONS	WITHIN 72 HOURS.
PRE-SERVICE DECISIONS	WITHIN 30 DAYS.
POST-SERVICE DECISIONS	WITHIN 60 DAYS.

Appeals Denial Notices
Notice of a Final Adverse Benefit Determination (including a partial denial) will be provided to you by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time periods noted above.

A notice that a claim appeal has been denied will include:

- The specific reason or reasons for the Final Adverse Benefit Determination;
- Reference to the specific plan provision upon which the determination is based;
- If any internal Molina rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to You, free of charge;
- A statement of Your right to external review, a description of the external review process, and the forms for submitting an external review request, including release forms authorizing Molina to disclose protected health information pertinent to the external review; and
- If a Final Adverse Benefit Determination is based on Medical Necessity, Experimental or Investigational treatment or similar exclusion or limitation, the notice will provide an explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of this Agreement to Your medical circumstances. In addition to the information provided in the notice, You have the right to request the diagnosis and treatment codes and descriptions upon which the determination is based. For assistance with appeals, complaints or the external review process You may write or call:

  Ohio Department of Insurance
  Attn: Consumer Affairs
  50 West Town Street
  Suite 300
  Columbus, OH 43215-1067

  Consumer Affairs: https://secured.insurance.ohio.gov/ConsumerServ/ConServComments.asp

Consumer Complaints:
http://Insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx
Phone: 614-644-2673 or 800-686-1526 or
TDD: 614-644-3745
Fax: 614-644-3744

External Review
Understanding the External Review Process
After you receive a Final Adverse Benefit Determination You may request an external review if you believe that a healthcare service has been improperly denied, modified, or delayed on the grounds that the healthcare service is not Medically Necessary.

Opportunity for External Review
An external review may be conducted by an Independent Review Organization (IRO) for Final Adverse Benefit Determinations involving Medical Necessity or medical judgment or by the Ohio Department of Insurance if the Final Adverse Benefit Determination involves a determination that the medical service is not covered by this Agreement. Molina will not choose or influence the IRO's reviewers.

There are three types of IRO reviews involving Medical Necessity or medical judgment, 1) standard external review, 2) expedited external review, and 3) external review of Experimental or Investigational treatment.

Standard External Review
A standard external review is normally completed within 30 days and applies to Adverse Benefit Determinations involving medical judgment.

Expedited External Review
An expedited review for urgent medical situations, including reviews of Experimental or Investigational treatment involving an urgent medical situation are normally completed within 72 hours and can be requested if any of the following applies:

- Your treating physician certifies that the Adverse Benefit Determination involves a medical condition that could seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal or a standard external review
- The Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care service for which You received emergency services, but have not yet been discharged from a facility
- An expedited internal appeal is in process for an Adverse Benefit Determination of Experimental or Investigational treatment and Your treating physician certifies in writing that the recommended health care service or treatment would be significantly less effective if not promptly initiated

External Review of Experimental and Investigational Treatment
Requests for standard or expedited external reviews that involve Adverse Benefit Determinations that a treatment is Experimental or Investigational may proceed if Your treating physician certifies one of the following:

- Standard health care services have not been effective in improving your condition,
- Standard health care services are not medically appropriate for you, or
- No available standard health care service covered by Molina is more beneficial than the requested health care service

Request for External Review in General

- You must request an external review within 180 days of the date of the notice of Final Adverse Benefit Determination issued by Molina.
- All requests must be in writing, except for a request for an expedited external review.
- Expedited external reviews may be requested electronically or orally.
- If the request is complete Molina will initiate the external review and notify you in writing that the request is complete and eligible for external review.
- The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information
- The notice will inform You that, within 10 business days after receipt of the notice, You may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review
- Molina will also forward all documents and information used to make the Adverse Benefit Determination to the assigned IRO or the Ohio Department of Insurance (as applicable).
- If the request is not complete Molina will inform You in writing and specify what information is needed to make the request complete.
- If Molina determines that the Adverse Benefit Determination is not eligible for external review, Molina will notify you in writing and provide You with the reason for the denial and inform You that the denial may be appealed to the Ohio Department of Insurance.
- The Ohio Department of Insurance may determine the request is eligible for external review regardless of the decision by Molina and require that the request be referred for external review. The Department's decision will be made in accordance with the terms of the Molina and all applicable provisions of the law.
- Molina will pay the costs of the external review.

IRO Assignment
The Ohio Department of Insurance maintains a secure web based system that is used to manage and monitor the external review process. When Molina initiates an external review by an IRO in this system, the Ohio Department of Insurance system randomly assigns the review to an Ohio accredited IRO that is qualified to conduct the review based on the type of health care service. Molina and the IRO are automatically notified of the assignment.

IRO Review and Decision
The IRO must forward, upon receipt, any additional information it receives from You to Molina. At any time Molina may reconsider its Adverse Benefit Determination and provide coverage for the health care service. Reconsideration will not delay or terminate the external review. If

Molina reverses the Adverse Benefit Determination, We will notify You, the assigned IRO and the Ohio Department of Insurance within one day of the decision. Upon receipt of the notice of reversal by Molina, the IRO will terminate the review.

In addition to all documents and information considered by Molina in making the Adverse Benefit Determination, the IRO must consider things such as; Your medical records, the attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under this Agreement and the most appropriate practice guidelines.

The IRO will provide a written notice of its decision within 30 days of receipt by Molina of a request for a standard review or within 72 hours of receipt by Molina of a request for an expedited review. This notice will be sent to you, the Molina and the Ohio Department of Insurance and must include the following information.

- A general description of the reason for the request for external review
- The date the independent review organization was assigned by the Ohio Department of Insurance to conduct the external review
- The dates over which the external review was conducted
- The date on which the independent review organization's decision was made
- The rationale for its decision
- References to the evidence or documentation, including any evidence-based standards, that was used or considered in reaching its decision

Binding Nature of External Review Decision
An external review decision is binding on Molina except to the extent Molina has other remedies available under state law. The decision is also binding on you except to the extent that You have other remedies available under applicable state or federal law

You may not file a subsequent request for an external review involving the same Adverse Benefit Determination that was previously reviewed unless new medical or scientific evidence is submitted to Molina

If You Have Questions About Your Rights or Need Assistance
You may contact:
Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300, Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)

Contact ODI Consumer Affairs:
https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp

File a Consumer Complaint:
http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

Department of insurance External review
You may request an external review of a Final Adverse Benefit Determination by the Ohio Department of Insurance if you believe that a healthcare service has been improperly denied, modified, or delayed on the grounds that the healthcare service is not covered under this Agreement or You are denied an external review of an Adverse Benefit Determination or Final Adverse Benefit Determination. You may contact the Ohio Department of Insurance:

Ohio Department of Insurance
ATTN: External Review Unit
50 West Town Street, Suite 300, Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)

Provider Claim Disputes

Provider Claim Disputes and shall be sent to the following address:

Molina Healthcare of Ohio, Inc. Attention: Provider Services P.O. Box 349020 Columbus, Ohio 43234-9020
Fax: (866) 713-1893

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

Molina 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, Molina 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.