Section 11. Complaints, Grievance and Appeals Process

MEMBER GRIEVANCE AND APPEAL PROCESS

Molina Healthcare Members or Member's personal representatives have the right to file a grievance and/or submit an appeal through a formal process. This section addresses the identification, review and resolution of Member grievances and appeals. Below is Molina Healthcare's Member Grievance and Appeals Process.

GRIEVANCE PROCESS "Grievance" means a verbal or written complaint submitted by or on behalf of a Member regarding service delivery issues other than denial of payment for or non-provision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or dissatisfaction with the service provided by Molina Healthcare.

You can file a grievance with your health plan if you are not happy with the way you were treated, the quality of care or services you received, you have problems getting care, or billing issues. You may file a Grievance, in writing, or by telephone. You must file Your Grievance within one hundred eighty (180) days from the day the incident or action occurred which caused you to be unhappy. If you need help filing a grievance, call Member Services at (888) 858-3492. To file a grievance contact:

Molina Healthcare

Attention: Member Appeals	**Phone:** (888) 858-3492
PO Box 4004	**Fax: (425) 424-1172 or** (877) 814-0342
Bothell, WA 98041-4004	**Email: wamemberservices@molinahealthcare.com**

Molina will keep your grievance private. We will let you know we received your grievance within 72 hours of the receipt our receipt of the request. We will resolve your grievance within 30 calendar days and tell you how it was resolved.

APPEAL PROCESS

An appeal is a request to review a denied service or referral or when you receive an Adverse Benefit Determination. You can appeal our decision if a service was denied, reduced or ended early due to an Adverse Benefit Determination.

"Adverse Benefit Determination" means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including a denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's or applicant's eligibility to participate in this plan, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Below are the two steps in the appeal process:

STEP 1: Molina Appeal (Internal Review)

STEP 2: Independent Review (External Review)

When the Internal Review or Appeal is final, you may request an External Review or Appeal of the Final Internal Adverse Benefit Determination.

Continuation of Services During the Appeal Process

If you are receiving services (or supplies) that are the subject of an Internal Review or Appeal, those services will be continued until the Internal Review or Appeal is resolved if you request the continuation. However, if Molina Healthcare prevails on final determination of the Internal Review or Appeal, you may be responsible for the cost of the coverage received during the review period. If you decide to pursue External Review of the appeal (with IRO) and if the IRO determines the service is Medically Necessary or appropriate for coverage under the Policy then Molina Healthcare will provide or pay for the health care service.

STEP 1 – Molina Appeal (Internal Review)

Requests for Internal Review or Appeal of Adverse Benefit Determinations must be received within 180 days of your receipt of an Adverse Benefit Determination. Requests for Internal Review or Appeals may be made by calling Molina Healthcare at 888-858-3492 between 8:00 a.m. to 5:00 p.m. PT Monday through Friday, or in writing and sent to the following mailing address, fax or electronic mail address:

Molina Healthcare

Grievance and Appeals Unit

P.O. Box 4004

Bothell, WA 98041

Fax: (425) 424-1172 or (877) 814-0342

Email: wamemberservices@molinahealthcare.com

www.molinahealthcare.com

You may choose someone, including an attorney or provider, to represent you and act on your behalf. You must sign a consent form allowing this person to represent you except in situations where the providers are seeking an expedited review (faster decision) of an adverse benefit determination on behalf of you the provider may act as your representative even if you have not formally notified the Molina of the designation. Molina Healthcare does not cover any fees or payments to your representatives. That is your responsibility.

We will send you a letter acknowledging receipt of your request for Internal Review or Appeal within 72 hours of our receipt of the request. Molina Healthcare's Internal Review or Appeal procedures will be completed within fourteen (14) calendar days for Adverse Benefit Determinations and twenty (20) calendar days for appeals involving Experimental and Investigational procedures. We may extend the time it takes to make a decision by up to 16 additional days if we notify you of the extension and the reason for the extension. Any further extensions by us are subject to your informed written consent to an extension and includes a specific agreed-upon date for determination. An extension will not extend the time for a determination beyond thirty (30) calendar days without your written consent.

You may submit information, comments, records and other items to assist in the review. You may review and copy our records and information relevant to the claim free of charge. We will consider all information submitted prior to making our determination. Our review panel will be performed by persons who were not involved in the original decision and who are not subordinates of the persons who made the original decision.

After the Internal Review or Appeal is complete, We will send you a written decision on your appeal determination and will provide information about what we considered, including the clinical basis for our determination and how you can obtain the clinical review criteria used to help make the decision free of charge. If applicable, we will also provide you with information for obtaining an External Review or Appeal of a Final Internal Adverse Benefit Determination.

STEP 2 - Independent Review Organization (External Review)

If you disagree with Molina's appeal decision, you can ask for an External Review with Independent Review Organization. Within 180 days after you have received our Final Internal Adverse Benefit Appeal Determination, or if we have not responded to your request for an Internal Review or Appeal within the time periods noted above, you may request an External Review or Appeal from an Independent Review Organization ("IRO"). Requests for External Review or Appeals must be in writing and sent to the following mailing address, fax or electronic mail address:

Molina Healthcare

Grievance and Appeals Unit

P.O. Box 4004

Bothell, WA 98041

Fax: (425) 424-1172 or (877) 814-0342

Email: wamemberservices@molinahealthcare.com

www.molinahealthcare.com

Upon receipt of a valid request for an External Review or Appeal, Molina will arrange for the review from an Independent Review Organization (IRO) at no cost to you, and will provide you with the IRO contact information within 24 hours of selecting the IRO. The IRO is unbiased and not controlled by us. We will provide the IRO with the appeal documentation, but you may also provide them with information.

The IRO process is optional and you pay no application or processing fees of any kind. You have the right to give information in support of your request and have 5 business days from the request for an External Review or Appeal to submit any supporting written information to the IRO. If you are receiving services that are the subject of the appeal, those services will be continued until the matter is resolved by the IRO if you request the continuation. If our Adverse Benefit Determination is upheld by the IRO, you may be responsible for paying for any services that have been continued during the External Review or Appeal.

The dispute will be submitted to the IRO's medical reviewers who will make an independent determination of whether or not the care is Medically Necessary or appropriate and the application of this Policy's coverage provisions to your health care services. You will get a copy of the IRO's Final External Review Decision. If the IRO determines the service is Medically Necessary or appropriate for coverage under the Policy, Molina Healthcare will provide the health care service.

If your case involves Experimental or Investigational treatment, the IRO will ensure that adequate clinical and scientific experience and protocols are taken into account.

For non-urgent cases, the IRO must provide its determination within the earlier of fifteen (15) days after the IRO receives the necessary information or twenty (20) days of receipt of your request.

EXPEDITED REVIEW (FASTER DECISIONS)

REQUEST FOR INTERNAL EXPEDITED REVIEW

You may request an expedited Internal Review or Appeal of an Adverse Benefit Determination if one of the following conditions apply:

- You are currently receiving or have been prescribed treatment or benefits that would end

because of the Adverse Determination.

- If your provider believes that a delay in treatment based on the standard review time may seriously jeopardize your life, overall health or ability to regain maximum function, or would subject you to severe and intolerable pain.
- If the Adverse Determination is related to an admission, availability of care, continued stay, or emergency health care services and You have not been discharged from the emergency room or transport service.

Requests for expedited Internal Reviews or Appeals may be made in writing or by telephone.

Providers seeking expedited review of an adverse benefit determination or a denied service or referral on behalf of a You may act as your representative even if you have not formally notified Molina Healthcare of the designation.

You, or a person designated by you to assist, or your provider may contact us by telephone or in writing at:

- Call Molina Healthcare toll-free at 1 (888) 858-3492, Monday through Friday, 8:00 a.m. - 5:00 p.m. PT.

- Molina Healthcare

  Grievance and Appeals Unit

  P.O. Box 4004

  Bothell, WA 98041

  Email: wamemberservices@molinahealthcare.com

  www.molinahealthcare.com

Formal responses to an expedited Internal Review or Appeal will be issued preferably within twenty-four hours (24 hours), but in no case later than seventy-two hours (72 hours) after your initial contact with us.

REQUEST FOR EXTERNAL EXPEDITED REVIEW

You may request an expedited External Review or Appeal if one of the following conditions apply:

- You receive a Final Adverse Benefit Determination concerning an admission, availability of care, continued stay, or health care service for which you received emergency services and have not been discharged from the facility.
- You receive a Final Adverse Benefit Determination involving a medical condition for which the standard external review time would seriously jeopardize your life or health or jeopardize your ability to regain maximum function.
- Your request for a concurrent expedited review is granted.

If the External Review or Appeal is expedited, the IRO must notify you within 72 hours of its Final External Review Decision. If the notice is not in writing, the IRO must provide you with written confirmation of its Final External Review Decision within 48 hours after the date of the decision.

For more information regarding the External Review or Appeal process, or to request an appeal, please call Molina Healthcare toll-free at 1 (888) 858-3492.

REQUEST FOR CONCURRENT EXPEDITED REVIEW

You may also request a concurrent expedited review of an Adverse Benefit Determination, which means that the Internal Review or Appeal and the External Review or Appeal are handled at the same time. Concurrent expedited reviews are available if one of the following conditions applies:

- You are currently receiving or have been prescribed treatment or benefits that would end because of the Adverse Determination.
- If your provider believes that a delay in treatment based on the standard review time may seriously jeopardize your life, overall health or ability to regain maximum function, or would subject you to severe and intolerable pain.
- If the Adverse Determination is related to an admission, availability of care, continued stay, or emergency health care services and you have not been discharged from the emergency room or transport service.

Requests for concurrent expedited review may be made in writing or by telephone. You, a person designated by you to assist, or your provider may contact us by telephone or in writing at:

- Call Molina Healthcare toll-free at 1 (888) 858-3492, Monday through Friday, 8:00 a.m. - 5:00 p.m. PT.

- Molina Healthcare

  Grievance and Appeals Unit

  P.O. Box 4004

  Bothell, WA 98041

  Email: wamemberservices@molinahealthcare.com

  www.molinahealthcare.com

Molina Healthcare will issue a formal response preferably within twenty-four hours (24 hours), but in no case later than seventy-two hours (72 hours) after your initial contact with us.

Washington State Office of the Insurance Commissioner

If you have any questions or complaints regarding our handling of your Grievance or appeal, you may contact the Washington State Office of the Insurance Commissioner. A Washington State Office of the Insurance Commissioner representative will review your issues, and if the representative can't help you, he or she will point you in the right direction for further assistance.

Contact Information:

Consumer Protection Division

PO Box 40256

Olympia, WA 98504-0256

Call 800-562-6900 or

Call 360-725-7080

TDD 360-586-0241

Fax to 360-586-2018

Email CAP@oic.wa.gov

Provider Claims Dispute

In the event a Provider determines a claim has been improperly denied or underpaid, the Provider may make a written request for payment: (1) within 24 months after the date the claim was denied or payment intended to satisfy the claim was made; (2) within 30 months after the date the claim was denied or payment intended to satisfy the claim was made if the request is related to coordination of benefits with another carrier or entity responsible for payment of the claim. The Provider may not request payment be made any sooner than six months after Molina Healthcare's receipt of the request. Any request for review of denied or underpaid claims must be submitted to Molina Healthcare in accordance with the requirements stated in this section and conform to the following instructions:

The written request must:

- Specify why the Provider believes Molina Healthcare owes the payment

- In the case of coordination of benefits, include the name and mailing address of any entity that has disclaimed responsibility for payment
- Be addressed to the attention of Molina Healthcare's Provider Services Department
- Include the claim number or the authorization number
- Clearly indicate "Denied Claims Review Request" or "Adjustment Request"
- Include all pertinent information including but not limited to, claim number, Member identifier, denial letter, supporting medical records and any new information pertinent to the request

Molina Healthcare will render a decision on all disputed claims within sixty (60) days of receipt of the request.

Request for Denied Claims Review submitted without this documentation may be delayed. Denied Claim Review Requests submitted untimely from the original decision will be denied. Request for denied claims review by Molina Healthcare should be e-mailed at MHWProviderServicesInternalRep@Molinahealthcare.com or mailed or faxed to:

Provider Services Department

PO Box 4004

Bothell, WA 98041-4004

Fax: (425) 424-1172 or (877) 814-0342

The Provider will be notified of Molina Healthcare's decision in writing within 60 days of receipt of the Denied Claims Review Request. Providers are reminded they can NOT bill the Member when a denial for covered services is upheld per review.