Provider Dispute Resolution and Member Appeals

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: How do I report a grievance?

Grievances are complaints about:

- The way you were treated,
- The quality of care or services you received,
- Problems getting care,
- Billing issues.

If you need help filing a grievance, call (800) 869-7165. We will let you know we received your grievance within two business days. We will try to take care of your grievance right away. We will resolve your grievance within 45 days and tell you how it was resolved.

APPEAL PROCESS

An appeal is a request to review a denied service or referral. You can appeal our decision if a service was denied, reduced, or ended early. Below are the steps in the appeal process:

STEP 1: Molina Healthcare Appeal
STEP 2: State Hearing
STEP 3: Independent Review
STEP 4: Health Care Authority (HCA) Board of Appeals Review Judge

Continuation of Services During the Appeal Process

If you want to keep getting previously approved services while we review your appeal, you must tell us within 10 calendar days of the date on your denial letter. If the final decision in the appeal process agrees with our decision, you may need to pay for services you received during the appeal process.

STEP 1 – Molina Healthcare Appeal: How do I ask for an appeal?

You have 60 calendar days after the date of Molina's denial letter to ask for an appeal. You or your representative may request an appeal or may submit information about your case over the phone, in person, or in writing. You may fax the information to (877) 814-0342. Within 5 calendar days, we will let you know in writing that we got your appeal. Molina can help you file your appeal. If you need help filing an appeal, call (800) 869-7165.

You may choose someone, including a lawyer or provider, to represent you and act on your behalf. You must sign a consent form allowing this person to represent you. Molina does not cover any fees or payments to your representatives. That is your responsibility.

Before or during the appeal, you or your representative may look at and have copies of your file, medical records, or other documents considered in the appeal. If you want copies of the guidelines we used to make our decision, we can give them to you free of charge. We will keep

your appeal private. We will send you our decision in writing within 14 calendar days, unless we tell you we need more time. Our review will not take longer than 28 calendar days.

STEP 2 – State Hearing: How do I ask for a legal review?

If you disagree with Molina's appeal decision, you can ask for a State Hearing. You must complete Molina's appeal process before you can have a hearing. You must ask for a hearing within 120 calendar days of the date on the appeal decision letter. When you ask for a hearing, you need to say what service was denied, when it was denied, and the reason it was denied.

Your provider may not ask for a Hearing on your behalf. To ask for a State Hearing, contact Office of Administrative Hearings:

Phone: 1-800-583-8271 P.O. Box 42489, Olympia, WA 98504-2489

You may consult with a lawyer or have another person represent you at the Hearing. If you need help finding a lawyer, check with the nearest Legal Services Office or call the NW Justice CLEAR line at 1-888-201-1014 or visit their website at www.nwjustice.org.

STEP 3 - Independent Review: How do I ask for an Independent Review?

An Independent Review is a review by a doctor who does not work for Molina. If you do not agree with the decision from the State Hearing, you can ask for an independent review within 21 calendar days of the Hearing decision or you may go directly to Step 4. Call (800) 869-7165 for help. Any extra information you want us to look at must be given to us within five days of asking for the independent review. If you ask for this review, your case will be sent to an Independent Review Organization (IRO) within three working days. You do not have to pay for this review. Molina will let you know the decision.

STEP 4 – Health Care Authority (HCA) Board of Appeals: How do I ask for another legal review?

You can ask for a final review of your case by the HCA Board of Appeals Review Judge. You must ask for this within 21 calendar days after the IRO decision is mailed. The decision of the HCA Board of Appeals is final. To ask for this review contact:

HCA Board of Appeals
P.O. Box 42700
Olympia, WA 98504-2700

Phone: (360) 725-0910 Fax: (360) 507-9018
Toll-free: (844) 728-5212

OTHER INFORMATION

Billed for services: If you get a bill for health care services, call (800) 869-7165.

Expedited (faster) Decisions: If you or your provider think waiting for a decision would put your health at risk, you may ask for an expedited (faster) appeal, state hearing, or IRO. Information that you think we need to look at must be given to us quickly. We will review your request and make a fast decision. If we decide your health is not at risk, we will let you know and we will follow the regular timeframe to make our decision.

Second Opinion: At any time you can get a second opinion about your health care or condition. Call (800) 869-7165 to find out how to get a second opinion.

Exception to Rule: Your doctor may ask us to approve a service for you that is not covered. This is called an Exception to Rule (ETR). To be approved, your need must be different from most people and no other covered, less costly service will meet your need. If we deny you a service because it is not covered, you may ask for an appeal. This decision is final. You may ask for a hearing only to review if we correctly determined the service you are asking for is not covered.

Limited Benefit: Your doctor may ask us to approve more services for you than your benefit package allows. It may be more in scope, number, length of time, or how often a service is provided. An example is more adult physical therapy visits than the 12 visits the benefit allows. This is called a Limitation Extension (LE). To be approved, it must meet the rules in WAC 182-501-0169:

- It must be asked for before you get more of the service.
- You must have gotten better from the services so far and it must be likely that you will continue to get better with more services or be likely that you would get worse without more services.

You can ask for an appeal at the same time as your doctor asks for a LE.

State-Only Funded Services are Limited: *If this applies to you, we will let you know.* Services paid by State Only money are limited. If the money runs out, we cannot approve the service for you even if we agree the services are needed. If you are in the middle of an appeal or a hearing when the money runs out, we cannot continue the process.

Provider Dispute Resolution Process

The Provider Dispute Resolution process (different from Appeals on behalf of Members) offers recourse for Providers who are dissatisfied with the payment or denial of a claim from Molina or any of its delegated medical groups/IPAs. Molina follows the Best Practice Recommendation for Extenuating Circumstances.

In the event a Provider would like to dispute a claim, the Provider may make an electric request via the Molina Portal, fax or e-mail: (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's receipt of the request. Any request for review of disputed claim must be submitted to Molina in accordance with the requirements stated in this section

Molina requires submission of your dispute through one of three options:

Provider WebPortal: (portal login here)
To submit a dispute you will need to be in the Claims Status Inquiry module. Once you have identified the claim you are disputing you can click on the "Appeal Claim" button located at the bottom of the page. When you are ready to submit the dispute click on the "Submit" button.

The benefits of submitting your dispute request electronically via the WebPortal include:

- The member, claim number and provider information auto populate in the form
- Electronically attach chart notes or any other documentation as part of the dispute
- Type additional information you would like included in the text box regarding your dispute request. Specify why the Provider believes the services should be compensated or adjusted. If the service was denied for no prior authorization/notification you must include the extenuating circumstances as to why the prior authorization was not obtained
- In the case of coordination of benefits, include the name and mailing address of any entity that has disclaimed responsibility for payment including the denied EOB
- Receive an electric acknowledgment letter immediately following submission
- Free of charge, no more postage

Fax & Email:

The Provider Dispute Resolution Request form must be completed with your request via e-mail or fax.

- Complete all elements of the Dispute Resolution Request form located at http://www.molinahealthcare.com/providers/wa/medicaid/forms/Pages/fuf.aspx. Including supporting medical records and any other required documentation for review of your request. Request forms that are incomplete or missing required information will not be reviewed and will be returned to the provider without review. Disputes submitted untimely from the original decision will be denied.
- If the dispute is regarding a claim denied for no prior authorization, you must include the extenuating circumstance as why authorization was not obtained. Extenuating Circumstances include; the inability to know member had Molina coverage, the inability to anticipate services in advance, inherent components where a service is essential to another, received misinformation from Molina, and untimely authorization decision from Molina. In the case of coordination of benefits, include the name and mailing address of any entity that has disclaimed responsibility for payment including the denied EOB. Include proof of due diligence including dated eligibility confirmation from another payer, such as eligibility screen shot and/or primary payers EOB showing denied services or ineligibility of coverage.

Additional information regarding extenuating circumstances can be found under the Best Practice Recommendation for Extenuating Circumstances.

- **Fax:** Molina Healthcare at (877) 814-0342
- **Email:** MHWProviderServicesInternalRep@Molinahealthcare.com You must complete the Dispute Resolution Request form cover sheet located on the Provider Website under the Forms section at: http://www.molinahealthcare.com/providers/wa/medicaid/forms/Pages/fuf.aspx

If your claim was denied by a delegated medical group/IPA you must make your initial review request through that group. The delegated medical group/IPA addresses for dispute submission are located below. If you have a direct contract with the delegated medical group/IPA, their decision is final. All other second level reviews for providers not directly contracted with the medical group/IPA should be sent to Molina per the process above.

Molina has two levels for the dispute process. Third level dispute requests will be denied as the dispute process has been exhausted.

Request for provider disputes for medical group/IPA should be submitted to:

- Kaiser Foundation Health Plan of the Northwest:
  Kaiser Permanente NCA NW Claims
  Waterpark 1
  2500 Havana St.
  Aurora, CO 80014
  Fax: N/A

- Confluence Health :
  Molina Managed Care
  PO Box 810
  Wenatchee, WA 98807
  Fax: (509) 665-3606

The Provider will be notified of Molina's / delegated medical group IPA decision within 60 days of receipt of the provider dispute request. Providers are reminded they can NOT bill the Member when a denial for covered services is upheld.

CODE EDIT POLICY RECONSIDERATOINS

A provider can request a reconsideration regarding a code edit policy in situations where the provider's and Molina Healthcare's correct coding policy sources conflict or where they may have different interpretations of a common correct coding policy source. The Provider will be notified of Molina Healthcare's decision in writing within 60 calendar days of the receipt of the Code Edit Reconsideration request, unless additional supporting documentation is required.

All requests for Code Edit Policy Reconsiderations must be submitted to Molina Healthcare in writing and should include the following:

- Explanation of why the provider does not agree with Molina Healthcare's current correct coding policy or interpretation. Include the supporting alternative policy information and the source where it can be found.
- Must clearly indicate "Code Edit Policy Reconsideration Request"
- Contact information for your organizations point person, i.e. name, contact number, e-mail address
- Relevant CPT/HCPCS codes or code combination examples
- Specific claim examples of denied services related to the code edit
- Must be addressed to the attention of Molina Healthcare's Provider Services Department

Code Edit Policy Reconsiderations do not apply to eligibility limitations, non-FDA approved services, medical policies, benefit determinations or contractual disputes. Code Edit Reconsiderations should be mailed, e-mailed or faxed to the addresses listed above under Provider dispute Process.