Grievances and 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

Grievances are complaints. 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. If you need help filing a grievance, call Member Services at (800) 869-7165. To file a grievance contact:

Molina Healthcare
Attention: Member Appeals
PO Box 4004
Bothell, WA 98041-4004

Phone: (800) 869-7165
Fax: (425) 424-1172
Email: wamemberservices@molinahealthcare.com

Molina will keep your grievance private. 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 calendar 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 Appeal
- STEP 2: State Hearing
- STEP 3: Independent Review
- STEP 4: Review Judge Decision

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 action, you may need to pay for services you received during the appeal process for the first sixty calendar days during which the appeal was pending. .

STEP 1 – Molina Appeal

Molina can help you file your appeal. If you need help filing an appeal, call Member Services at (800) 869-7165**.** Within 72 hours, we will let you know in writing that we got your appeal. 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. Molina does not cover any fees or payments to your representatives. That is your responsibility.

You have 90 calendar days after the date of Molina's denial letter to ask for an appeal. You or your representative may submit information about your case in person or in writing. 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 30 calendar days, unless you give us written consent.

STEP 2 – State Hearing:

If you disagree with Molina's appeal decision, you can ask for a State Hearing. You must complete Molina Healthcare's appeal process before you can have a hearing. You must ask for a hearing within 90 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:

- Go to your local Community Services Office or call the Statewide Customer Service Center at (800) 501-2233.
- Contact the Office of Administrative Hearings directly at (800) 583-8271, or write to them at: P.O. Box 42489, Olympia, Washington, 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 (888) 201-1014 or visit their website at www.nwjustice.org.

STEP 3 - Independent Review:

If you do not agree with the decision from the State Hearing, you can ask for an independent review. Call Member Services at (800) 869-7165 for help. 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. The IRO usually makes a decision within 15 calendar days. Molina Healthcare will let you know the outcome.

STEP 4 – Health Care Authority (HCA) Review Judge Decision:

If you do not agree with the IRO decision, you can ask for a final review of your case by the HCA Review Judge. You must ask for this within 21 calendar days after the IRO decision is mailed. The decision of the HCA Review Judge is final. To ask for this review contact:

HCA Review Judge
PO Box 45803
Olympia, WA 98504-5803

Phone: (360) 664-6100 Fax: (360) 664-6187
Toll-free: (877) 351-0002

Expedited (faster) Decisions

If you or your provider think waiting for a decision would put your health at risk, ask for an expedited appeal, state hearing, IRO or HCA Review Judge Decision. We will review your request and make a decision within 72 hours. If we decide your health is not at risk, we will follow the regular appeal process time to make our decision.

Second Opinion:

You can get a second opinion about your health care or condition. Call Member Services at (800) 869-7165 to find out how to get a second opinion.

Washington State Health Insurance Consumer Assistance Program
The Consumer Protection Division in the Washington State Office of the Insurance Commissioner can help you with questions and complaints. For help, contact:

Consumer Protection Division
PO Box 40256
Olympia, WA 98504-0256

Phone: Insurance Consumer Hotline (800) 562-6900

PROVIDER DENIED CLAIMS REVIEW

The Provider Denied Claims Review process (different from Appeals on behalf of Members) offers recourse for Providers who are dissatisfied with a denial or decision from Molina Healthcare or any of its delegated medical groups/IPAs.

Claims Dispute Process:
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.

If your claim was paid by a delegated medical group/IPA you must make your initial review request through that group (please see section 14 for additional information on the delegated medical groups/IPAs). If you have a direct contract with the delegated medical group/IPA, their decision is final. All other second level reviews should be sent to Molina Healthcare per the process above.

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 mailed, e-mailed or faxed to:

Provider Services Department
PO Box 4004
Bothell, WA 98041-4004

e-mail: MHWProviderServicesInternalRep@Molinahealthcare.com
Fax: (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.

CLAIM EDITING PROCESS

Molina Healthcare has a claims pre-payment auditing process that identifies frequent correct coding billing errors such as:

- Bundling and unbundling coding errors
- Duplicate claims
- Services included in global care
- Incorrect coding of services rendered

Coding edits are based on Current Procedural Terminology (CPT), Medicaid Purchasing Administration (MPA) guidelines, industry standard National Correct Code Initiative (NCCI) policy and guidelines and industry payment rules and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB). Variations from the standards listed are located on the Molina Healthcare website at:
http://www.molinahealthcare.com/medicaid/providers/wa/policies/pages/policies.aspx.

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:

Provider Services Department
PO Box 4004
Bothell, WA 98041-4004

e-mail: MHWProviderServicesInternalRep@Molinahealthcare.com
Fax: (877) 814-0342