Appeals and Grievances

Provider Appeals

The Molina Healthcare of Michigan Appeals team coordinates clinical review for Provider Appeals with Molina Healthcare Medical Directors.

All providers have the right to appeal any denial decision made by Molina. Any denied claim for a service that requires authorization is considered a post-service appeal. Our appeal process is objective, thorough, fair and timely. A Molina Healthcare Medical Director can also determine that a same specialty physician review may be needed.

Providers must submit all appeals via one of the methods listed below (listed in order of preference):

Online Provider Portal: http://provider.molinahealthcare.com/Provider/Login

Fax:
Molina Healthcare of Michigan
Attn: Provider Appeals
248-925-1768

Mail: (Molina accepts CD's)
Molina Healthcare of Michigan
Attn: Provider Appeals
880 West Long Lake Rd., Suite 600
Troy, MI 48098

Retrospective Authorization*

(*Retrospective Authorization is considered a request for initial authorization after a service has been rendered and/or failure to authorize services according to the required timeframes.)

Retrospective authorization is not a Molina Healthcare of Michigan process, except in the event of extenuating circumstances. An extenuating circumstance is defined as:

1. Provider did not know nor reasonably could have known that the patient was a Molina Healthcare Member at the time the service was rendered
   Examples:
   - Member does not have insurance cards on them at time they arrived
   - Eligibility IVR system is offline
   - Woman presents in labor and has other insurance, Molina is secondary insurer and card not presented at time of admission
   - Member has pending Medicaid at the time of service

2. Provider did not know nor reasonably could have known that patient needed a service that required authorization prior to the service being rendered
Examples:
   - Elective outpatient surgery authorization is obtained for a specific service however; the member presents with an additional and/or different service that requires an authorization.
   - Surgery for shoulder repair which turns out to be more extensive than planned.
   - Member originally requires an Elective surgery that does not require authorization. However, when the member presents an additional and/or different Elective surgery service is needed that requires authorization.
   - Planned diagnostic hysteroscopy which results in the removal of a leiomyoma (fibroids)
   - Member originally requires an Outpatient service that does not require authorization. However, when the member presents an additional and/or different Outpatient service is needed that requires authorization.
   - Member has had a TIA and is need of a Speech Therapy evaluation for swallowing. Evaluation indicates that 12 visits are needed. Evaluation + 6 visits do not require an authorization. The remaining visits would require and authorization.
   - Member originally requires an Outpatient service that does not require authorization. However, when the member presents an additional and/or different Outpatient service is needed that requires authorization.
   - Member is evaluated for a manual wheelchair which does not require an authorization. The evaluation showed that a power wheelchair was recommended which does require an authorization.

3. Molina Healthcare error

Documentation to demonstrate extenuating circumstances must be submitted at the time of the request. All requests for retrospective authorization with an extenuating circumstance must be received within 10 calendar days of becoming aware of the extenuating circumstance. Determinations, in this circumstance, will be based on medical necessity guidelines and UM policies and criteria.

There are two ways to request a Retrospective Authorization with extenuating circumstance.
Fax authorization request and clinical information (if required) to Healthcare Services at (800) 594-7404
Telephone (855) 322-4077

**Please note if there is a denied claim on file the Provider Appeal process will need to be followed. Refer to the Provider Appeals and Grievances Section.

Appeals and Grievances

Pre-Service Appeal*

(*Pre-service is considered an appeal of any adverse determination prior to rendering the requested service or procedure. If a claim has been denied for an authorization, please refer to the Post-Service Appeal process.)

In the event an authorization has been denied, providers may submit an appeal on behalf of the member (with written approval to act as a designated representative) within sixty (60) calendar days of the denial, prior to the service being completed. The provider may serve as designated representative for the member and act on their behalf (hereafter referred to as "representative"). The representative can be a friend, a family member, health care provider, or an attorney. An Authorized Representative Form can be found on Molina Healthcare's member website at http://www.molinahealthcare.com/providers/mi/medicaid/forms/Pages/fuf.aspx

Continued Stay Review

In the event of an inpatient admission authorization denial, providers may submit additional medical records and request a Continued Stay Review by contacting 1-855-322-4077

Note: Providers may review the UM criteria with Molina Healthcare or they may request a copy of the criteria used to make the medical necessity determination by fax or email.

A Molina Healthcare Medical Director is available for peer-to-peer consultation to discuss the denial decision with any treating practitioner regarding medical necessity.

Listed below are the timeframe requirements by line of business and service type:

	Medicaid/Marketplace	Medicare
Preservice	Requesting provider has five (5) business days from receipt of the denial notification to schedule a P2P. Scheduling Exceptions: A peer to peer review may be scheduled outside of the five (5) business day timeframe ONLY if the Molina physician reviewer was responsible for not attending the meeting at the scheduled time.	Requesting provider can request anytime PRIOR to an adverse determination being made. Scheduling Exceptions: None

	Medicaid/Marketplace	Medicare
	NOTE: The requesting provider must be available during the scheduled time or reschedule within the five (5) day timeframe	
Inpatient	An adverse or potential adverse determination can be changed to an approval at any time while the member is still inpatient or one (1) business day after notification of the adverse determination.	An adverse or potential adverse determination can be changed to an approval at any time while the member is still inpatient.
SNF/IPR	An adverse or potential adverse determination can be changed to an approval at any time while the member is still inpatient or one (1) business day after notification of the adverse determination	An adverse or potential adverse determination can be changed to an approval at any time while the member is still inpatient.
Pharmacy	Requesting provider has five (5) business days from receipt of the denial notification to schedule a P2P. Call 888-898-7969.	N/A
Out of timeframe for the Peer to Peer	Requesting provider is instructed to file an appeal on behalf of the member or submit a claim and follow the provider appeal/reconsideration/dispute process.	Requesting provider is instructed to file an appeal on behalf of the member or submit a claim and follow the provider appeal/reconsideration/dispute process.

Timeframe Requirements for Submission of Additional Information Following the Peer to		
	Medicaid/Marketplace	**Medicare**
Pre Service		
After discussing the case with the requesting provider, Molina MD requests that additional information be submitted to Molina,	Additional information must be received by the requesting provider within one (1) business day following the peer to peer	Additional information must be received by the requesting provider within one(1) business day following the peer to peer
	If the additional information is received AFTER the established turnaround times, thirteen (13) days for non-urgent and two (2) days for urgent preservice,	If the additional information is received AFTER one (1) business day following the peer to peer Molina will notify the provider stating that:

Timeframe Requirements for Submission of Additional Information Following the Peer to		
following the Peer to Peer:	Molina will notify the provider stating that: The initial decision will be upheld and Instruct the provider to file an appeal on behalf of the member or submit a claim and file a claims dispute/reconsideration.	The initial decision will be upheld and Instruct the provider to file an appeal on behalf of the member or submit a claim and file a claims dispute/reconsideration.
	Inpatient	
	Prior to discharge, see non highlighted row of Preservice section immediately above.	Prior to discharge, see non highlighted row of Preservice section immediately above.

*Due to volume, a denial may have been issued, however, Molina is still open to a clinical discussion even if we have already given an adverse determination.

There are circumstances where peer to peer conversations will not be initiated. These are listed below:

Medicaid/Marketplace	Medicare
A third party vendor, member or anyone other than the provider directing the care of the member A request was administratively denied (e.g. non-covered benefit or exhaustion of benefits) An appeal has been submitted and filed A peer to peer, for the same request, has already occurred. Post Service requests: services have been rendered (provided) Concurrent requests (concurrent review): The member has been discharged	Concurrent requests (concurrent review): The member has been discharged A request was administratively denied (e.g. non- covered benefit or exhaustion of benefits) An appeal has been submitted and filed

If the peer to peer is requested after 5 business days from receipt of the denial notification	
If any of the above apply Molina will notify the provider that: The initial decision will be upheld at this time; and Instruct the provider that a member appeal or claims dispute may be filed	

Post-Service Appeal*

(*Post-service is considered an appeal of any adverse determination after rendering a service or procedure.) There are two types of post service provider appeals: administrative decisions and medical necessity review.

Administrative Denials

Molina Healthcare has a one level appeal process for the practitioner/provider appeal of post-service administrative denials. An example of an administrative denial is failure to authorize services according to required time frames. Retrospective authorization is not a Molina Healthcare of Michigan process, except in the event of extenuating circumstances. If a clean claim has not been submitted and an extenuating circumstance exists, these requests should follow the Utilization Management section of the Molina Healthcare of Michigan Provider Manual.

Level 1

A. The appeal must include NEW supporting evidence and/or documentation justifying the service, care or treatment being appealed and reason for notification outside of Molina Healthcare notification timeframes. Portions of the medical record may be submitted.
    a. Reason Authorization was not obtained
    b. History and Physical
    c. Consultations
    d. Physician Progress Notes
    e. Laboratory Results
    f. Radiology Results
    g. Emergency Department Summary
    h. Physician Discharge Summary
    i. Leaving Against Medical Advice information
B. Upon receipt of the appeal, the Medical Director or other qualified physician will review all documentation submitted and fully investigate all aspects of the clinical care provided without deference to the original determination.
C. The Medical Director or other qualified physician will/may consult with a physician of the same or similar specialty as the case in review.

A decision will be rendered, and notification provided within 30 calendar days of the receipt of a post-service appeal.

Medical Necessity Denials

Molina Healthcare of Michigan has a two level appeal process for the practitioner appeal of post-service medical necessity denials. An example of medical necessity denials are inpatient admissions which did not meet medical necessity criteria guidelines.

Level 1

A. A practitioner/provider must submit a written appeal within 90 calendar days of the claims denial notification.
B. The appeal must include NEW supporting evidence and/or documentation justifying the service, care or treatment being appealed. The appeal must also include information to reference the specific location of the supporting evidence and/or documentation. Portions of the medical record may be submitted:
    a. History and Physical
    b. Consultations
    c. Physician Progress Notes
    d. Laboratory Results
    e. Radiology Results
    f. Emergency Department Summary
    g. Physician Discharge Summary
    h. Leaving Against Medical Advice information
C. Upon receipt of the appeal, the Medical Director or other qualified physician will review all documentation submitted and fully investigate all aspects of the clinical care provided without deference to the original determination.
D. The Medical Director or other qualified physician will/may consult with a physician of the same or similar specialty as the case in review.
E. A decision will be rendered and written notification provided within 30 calendar days of the receipt of a post-service appeal.

Level 2

A. If you disagree with the level 1 appeal decision , a practitioner must submit a second level written appeal within 90 calendar days of the date of the Level 1 denial notice. The request **must** clearly state it is for a level 2 review.
B. The written level 2 appeal request must include **additional supporting** documentation not previously submitted with the Level 1 Appeal. Some examples of additional supporting documentation include:
    a. a rebuttal to Molina's level 1 appeal denial rationale
    b. How the member met Inter Qual acute care criteria
    c. Clinical documentation (i.e. chart notes)

C. The appeal will/may be reviewed by a Medical Director or by a consultant of same or similar specialty.
D. The Medical Director will render a decision and written notification will be provided within 30 calendar days of the receipt of a post-service appeal.

Timely Filing, Code Edit, COB, and Over/Under Payment Appeal/Disputes

Molina Healthcare of Michigan has a Claim Dispute Request Form that must be completed for Timely Filing, Code Edit, COB, and Payment Disputes. Failure to complete the Claim Dispute Request form will result in a delay in processing the request. The Claim Dispute Request Form can be found on Molina's website under Health Care Professionals: Frequently Used Forms at: http://www.molinahealthcare.com/medicaid/providers/mi/forms/Pages/fuf.aspx

Timely Filing Appeal/Disputes

Timely Filing disputes must be submitted on a completed Claim Dispute Request Form with supporting documentation showing extenuating circumstances for not submitting the claim within standard timely filing limit. If claim was billed to another payer, please include the submission date and denial date by the other payer. For retro enrollment claims, include the date the members eligibility was updated to Molina.

Code Edit Appeal/Disputes (Correct Coding Initiative Edits)

CCI Edit disputes must be submitted on a completed Claim Dispute Request Form with supporting documentation and medical notes/reports within 90 calendar days of the clean claim remit date. In the event of a billing error, submit a corrected claim, not an appeal. Do not use a Claim Dispute Request Form to submit a corrected claim.

Coordination of Benefits (COB) Disputes

A COB dispute exists when Molina Healthcare requires a claim to be resubmitted with the primary payers Evidence of Payment attached. If the primary coverage is not applicable on the date of service, the COB dispute must be submitted with supporting documentation within 180 days of the primary payer's remit date. Complete a Claims Dispute Request Form.

Request for Binding Arbitration

A request for arbitration may be submitted in writing to MHM's Provider Inquiry Research and Resolution department after all MHM appeal processes have been exhausted. Arbitration must be initiated within one year of the date of service or an extenuating circumstance; otherwise it shall be deemed waived.

MHM's Legal Department will coordinate the binding arbitration process in accordance with the American Arbitration Association rules for Arbitration for Non-Contracted providers, and pursuant to the provisions of the Provider Agreement for Contracted providers. Arbitration disputes will be processed in a timely and efficient manner with adherence to State/Federal Regulations.

Send all written requests for arbitration to:
Molina Healthcare of Michigan
Attn: Provider Inquiry Research and Resolution (Arbitration)
880 West Long Lake Rd., Suite 600
Troy, MI 48098

Rapid Dispute Resolution

Molina Healthcare of Michigan supports the Michigan Department of Health and Human Services (MDHHS) Rapid Dispute Resolution Process (RDRP) for hospitals under the MDHHS Access Agreement that DONOT actively contract with the plan. The purpose of this policy and procedure is to ensure Provider disputes are processed in a timely and efficient manner with adherence to State/Federal Regulations. Provider disputes will be reviewed to determine the appropriate resolution.

Send all written requests for rapid dispute resolution to:
Molina Healthcare of Michigan
Attn: Provider Appeals (RDRP)
880 West Long Lake Rd., Suite 600
Troy, MI 48098

Provider Rights

Rights to copies of documents: A practitioner may request Molina Healthcare of Michigan to furnish all documents relevant to the member's appeal as well as copies of the actual benefit provision, guideline, protocol or criteria on which the appeal decision was based.

Right to know practitioners participating in the appeal: A practitioner may request Molina Healthcare to furnish the names, titles and qualifications of any medical experts whose advice was obtained on behalf of Molina Healthcare in connection with the appeal, without regard to whether the advice was relied upon in making the appeal decision.

Reporting

All Grievance/Appeal data, including Provider 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 monthly, quarterly and on an annual basis. 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 ten (10) 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).