Claim and Authorization Reconsideration Training

2021 | Molina Healthcare of Ohio

MOLINA HEALTHCARE

Authorization and Claim Reconsiderations:

Claim Reconsideration Request Form Requirements

As of Aug. 1, 2019, claim disputes or authorization reconsiderations submitted on an incorrect form, or submitted on a form that is not filled out completely, will be returned unworked. This change is based on the Jan. 2019 update Molina made to the authorization and claim reconsideration processes.

Request for Claim Reconsideration Form	• Must be submitted for any dispute that is related to a claim denial that is not due to an authorization
Authorization Reconsideration Form	• Must be attached to any request involving an authorization denial or update

Authorization and Claim Reconsiderations:

The appropriate form will be required to process the reconsideration.

- Request for Claim Reconsideration Form
- Authorization Reconsideration Form

These forms have been updated and are available on our website under the “Forms” tab. Please be sure you are accessing the current version of the form on our website or your request will be returned unworked.

- For more information regarding our Authorization and Claim Reconsideration processes please see the reference guides on our website on the “Manual Tab” under the section titled Quick Reference Guides & FAQs.

- These guides are specific to each line of business.
- Please confirm the line of business the member is eligible under and reference the correct guide for the reconsideration process and appeal rights.

Authorization and Claim Reconsiderations:

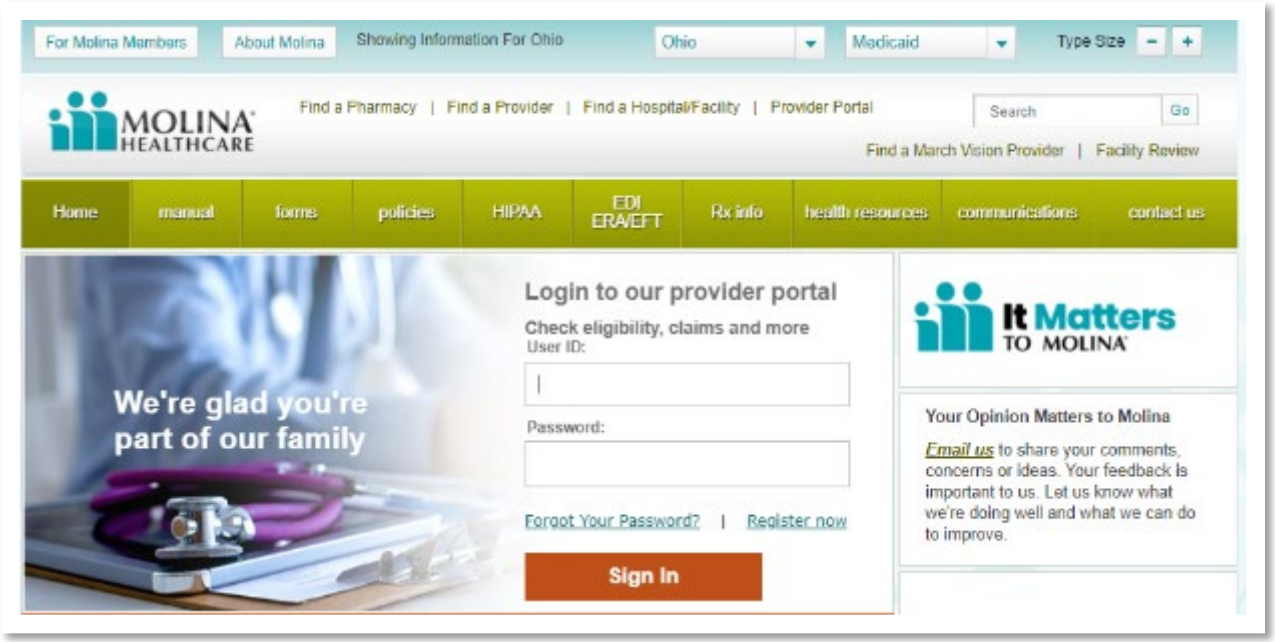
Claim Reconsideration Process (Not Related to an Authorization)

Submit a claim reconsideration only when disputing a payment denial, payment amount or code edit. Claim reconsiderations are applicable for disputes unrelated to clinical appeals or reconsiderations associated with pre-service and post-service authorization.

- Primary insurance Explanation of Benefits (EOB), corrected claims, and itemized statements are not accepted via claim reconsideration. Please refer to the Corrected Claims submission process guidelines.
- The Claim Reconsideration Request Form (CRRF) must be filled out entirely and include the claim number, or it will not be processed and the provider will be notified. Paper submissions received by mail will not be processed and the provider will be notified.
- The form and supporting documents can be submitted through our **Provider Portal** or the form can be faxed to (800) 499-3406

Provider Online Resources:

Provider Manual
Dental Manual
Provider Online Directories
Provider Portal
Preventive & Clinical Care Guidelines
Prior Authorization (PA) Information
Advanced Directives
Claims Information
Claims Reconsiderations
Pharmacy Information
HIPAA
Fraud, Waste and Abuse Information
Frequently Used Forms
Communications & Newsletters
Member Rights & Responsibilities
Contact Information



www.MolinaHealthcare.com/OhioProviders

Authorization Reconsiderations

Authorization Reconsideration Process

As a reminder, on Jan. 1, 2019, Molina Healthcare updated the Authorization Reconsideration process.

Pre-service and post-service authorization reconsiderations have been combined into a single process, and claims reconsiderations now follow a separate process.

This change impacted claim reconsiderations and authorization reconsiderations received on or after Jan. 1, 2019.

Authorization Reconsiderations: Medicaid and Marketplace

Pre-Service and Post-Service Authorization Reconsiderations Recourses

You can ask for one Member Appeal represented by the provider

A member appeal can be requested within 60 calendar days of the date on the authorization denial letter. If your patient wants you to appeal on his or her behalf, your patient must tell us this in writing using the Authorized Representative Form posted at www.MolinaHealthcare.com/OhioProviders.

You can ask for one Authorization Reconsideration

An Authorization Reconsideration can be submitted within 30 calendar days of the date on the authorization denial letter. Requests may be submitted whether a Peer-to-Peer is requested or not.

- Requests may be submitted through the Provider Portal or fax

You can ask for one Peer-to-Peer Review

The treating provider can request a Peer-to-Peer Review with the physician reviewer within 5 calendar days of the date on the authorization denial letter.

- Call Molina Healthcare Utilization Management at (855) 322-4079 from 8:30 a.m. to 5 p.m., Monday to Friday.
- Include 2 possible dates and times a licensed professional is available to conduct the review with a Molina Medical Director.

Molina Healthcare **Medicaid and Marketplace** Provider recourses for a denied authorization request.

Authorization Reconsiderations: Medicare and MyCare Ohio

Pre-Service and Post-Service Authorization Reconsiderations Recourses

Molina Healthcare **Medicare and MyCare Ohio** Provider recourses for a non-approved/denied authorization request.

You can ask for one Peer-to-Peer Review

- The treating provider can request a Peer-to-Peer Review with the physician reviewer within 5 calendar days of the date on the authorization non-approval/denial letter, or up to the date of discharge.
- Call Molina Utilization Management at (855) 322-4079 from 8:30 a.m. to 5 p.m., Monday to Friday.
- Include 2 possible dates and times a licensed professional is available to conduct the review with a Molina Medical Director.

NOTE: Due to regulatory requirements, for Outpatient decisions a Peer-to-Peer is a consultation only, a determination cannot be overturned.

Authorization Reconsiderations: Medicare and MyCare Ohio

Pre-Service and Post-Service Authorization Reconsiderations Recourses

Molina Healthcare **Medicare and MyCare Ohio** Provider recourses for a non-approved/denied authorization request.

Inpatient Only

- You can ask for one Authorization Reconsideration (Due to regulatory requirements, for outpatient decisions an authorization reconsideration is not available.)
- An Authorization Reconsideration can be submitted within 30 calendar days of the date on the authorization non-approval letter, or until the claim is processed.
- Requests may be submitted after the Peer-to-Peer is completed, or if a Peer-to-Peer was not requested within the stated timeframe.
- Requests may be submitted through the Provider Portal or fax

Authorization Reconsiderations: Medicare and MyCare Ohio

Pre-Service and Post-Service Authorization Reconsiderations Recourses

Molina Healthcare **Medicare and MyCare Ohio** Provider recourses for a non-approved/denied authorization request.

You can ask for one Member Appeal represented by the provider

- A member appeal can be requested within 60 calendar days of the date on the authorization denial letter.
- If your patient wants you to appeal on his or her behalf, your patient must tell us this in writing using the Authorized Representative Form posted at www.MolinaHealthcare.com/OhioProviders.

Authorization Reconsiderations

Quick Reference Guide

The grid below summarizes your options by type of authorization by line of business.

	Outpatient			Inpatient		
	Peer-to-Peer	Authorization Reconsideration	Provider Rep. Member Appeal	Peer-to-Peer	Authorization Reconsideration	Provider Rep. Member Appeal
Medicaid/ Marketplace	Yes	Yes	Yes	Yes	Yes	Yes
Medicare/ MyCare Ohio	Yes*	No	Yes	Yes	Yes	Yes

*As noted in the slide above, due to regulatory requirements, for Outpatient decisions a Peer-to-Peer is a consultation only, a determination cannot be overturned.

For additional information read the:

- Medicaid and Marketplace Authorization and Claim Reconsideration Guide available on the "Manual" on our Medicaid and Marketplace websites
- MyCare Ohio and Medicare Authorization and Claim Reconsideration Guide available on the "Manual" tab on our MyCare Ohio website.

Provider Portal

The Provider Portal is secure and available 24 hours a day, 7 days a week
Self-service Provider Portal options include:

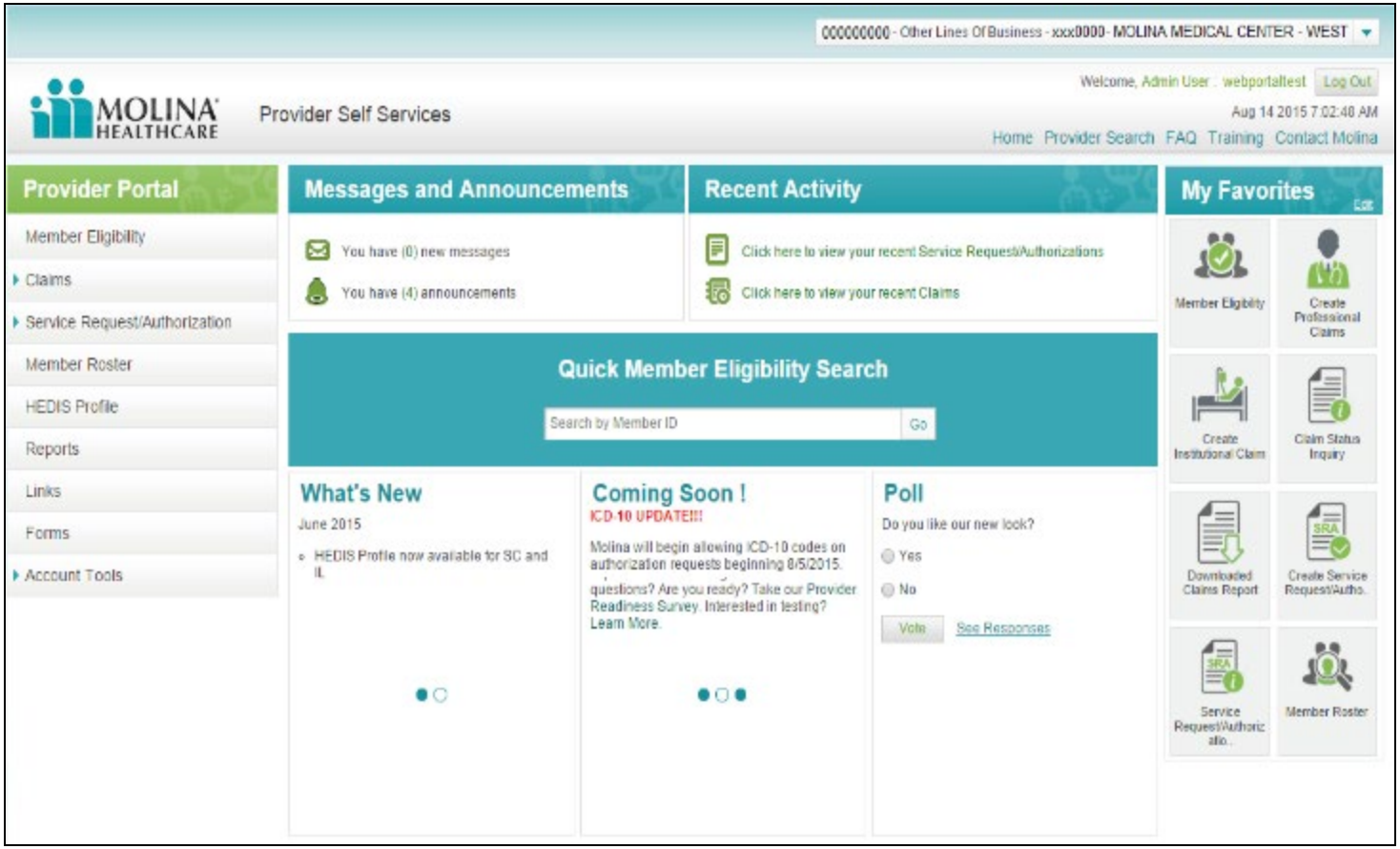
- Online Claim Submission
- Claims Status Inquiry
- Corrected Claims
- Healthcare Effectiveness Data and Information Set (HEDIS®) missed service alerts for members
- Member Eligibility Verification and History
- Update Provider Profile
- Online Claim Reconsideration Requests
- Member Nurse Advice Line Call Reports
- View Primary Care Provider (PCP) Member Roster
- Coordination of Benefits (COB)
- Check Status of Authorization Request
- Submit PA Requests

Molina offers monthly "It Matters to Molina" Provider Forums, and quarterly Provider Orientations. For more training information visit the Molina Provider Website and view the Provider Training dates and times.

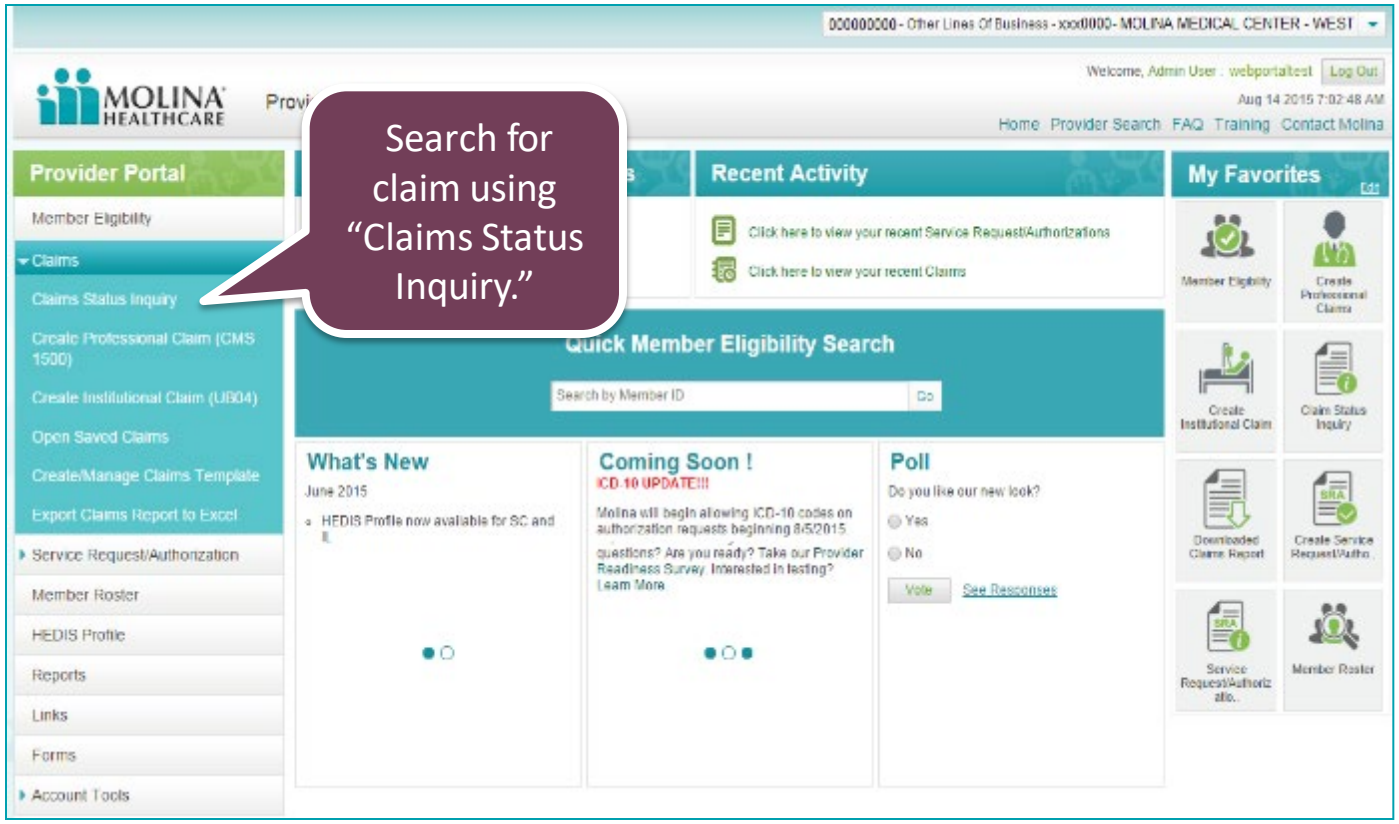
Email Molina at OHProviderRelations@MolinaHealthcare.com to sign up for the Molina Monthly Provider Bulletin. Please include your Provider Name, TIN and email address.

Provider Appeal Request Form

On the Home Page select the “Claims” drop-down menu.

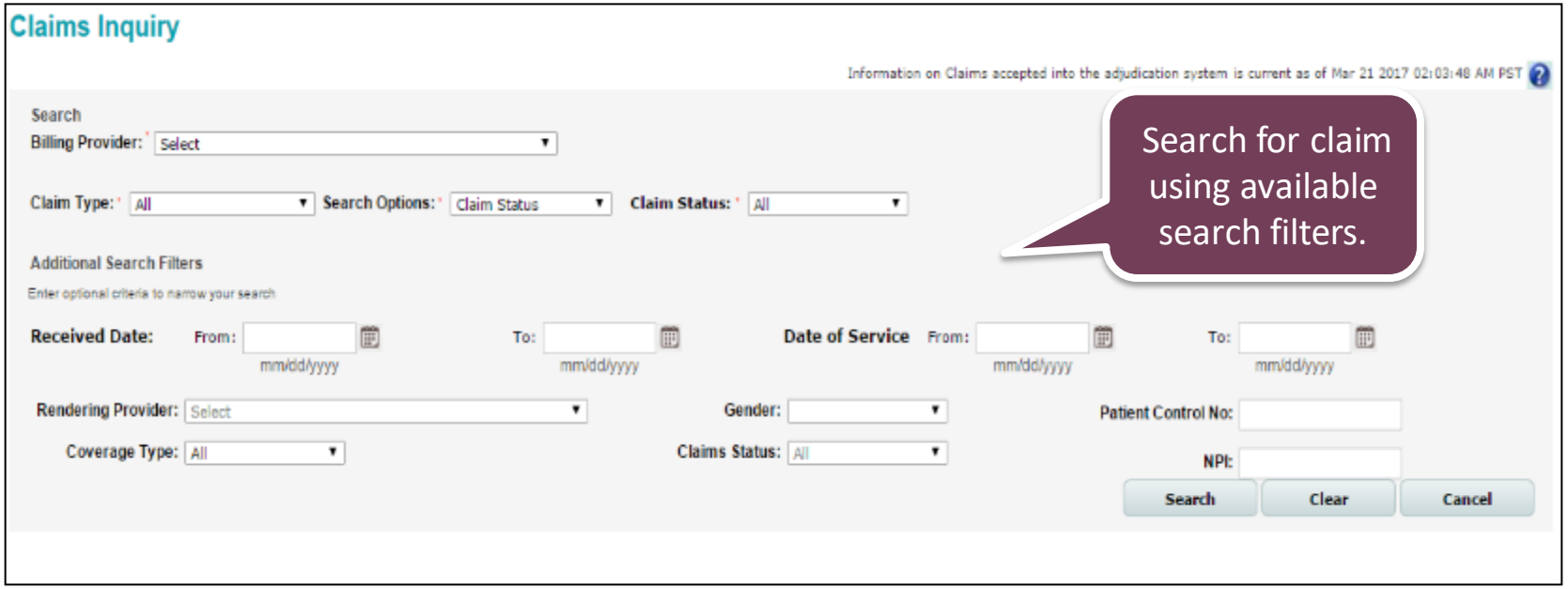


Provider Appeal Request Form



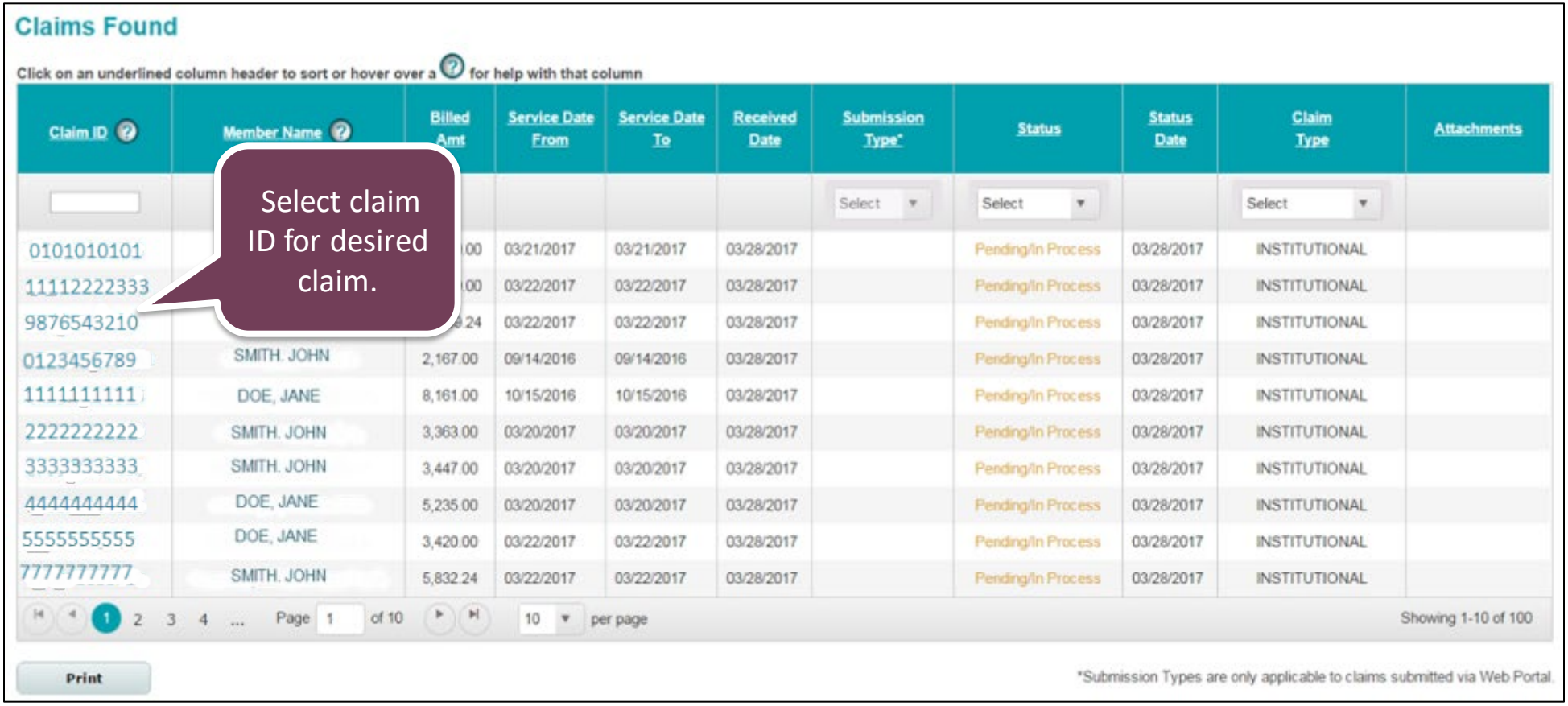
Once you select the Claims Status Inquiry feature, you may search for the claim you would like to appeal.

Provider Appeal Request Form



You may search for the desired claim by using any of the available search filters: claim status, claim number, date of service, etc.

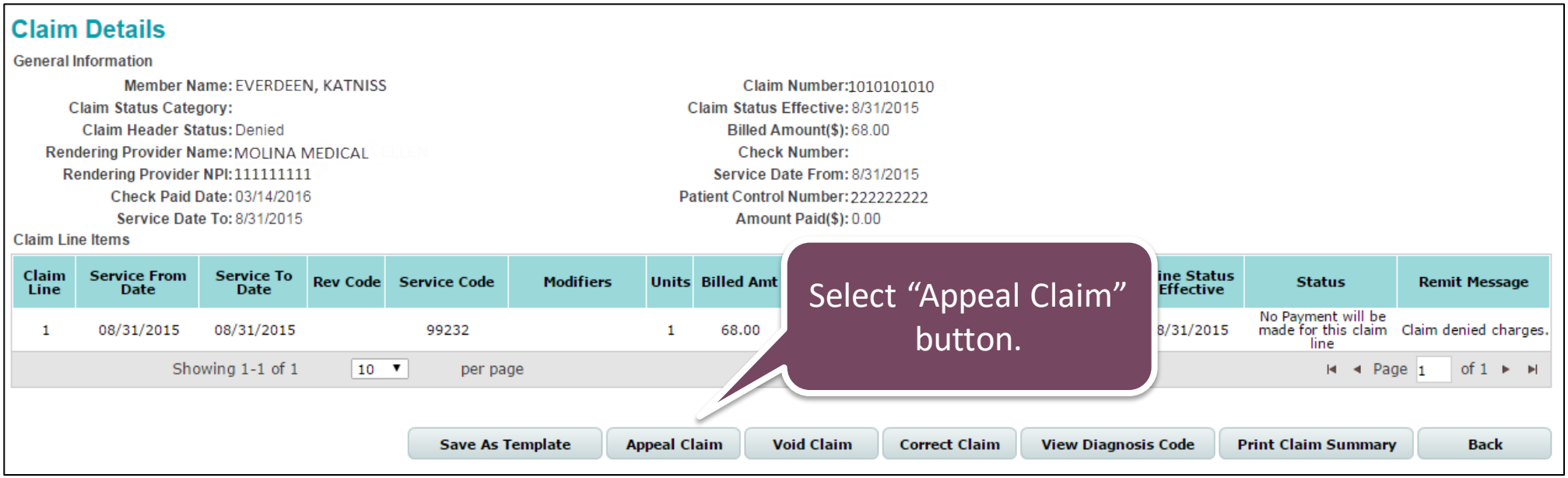
Provider Appeal Request Form



Once the search results display, click on the desired claim ID to access the claim details.

Provider Appeal Request Form

Once routed to the “Claim Details” page, you can access the Provider Appeal Request Form by selecting the “Appeal Claim” button.

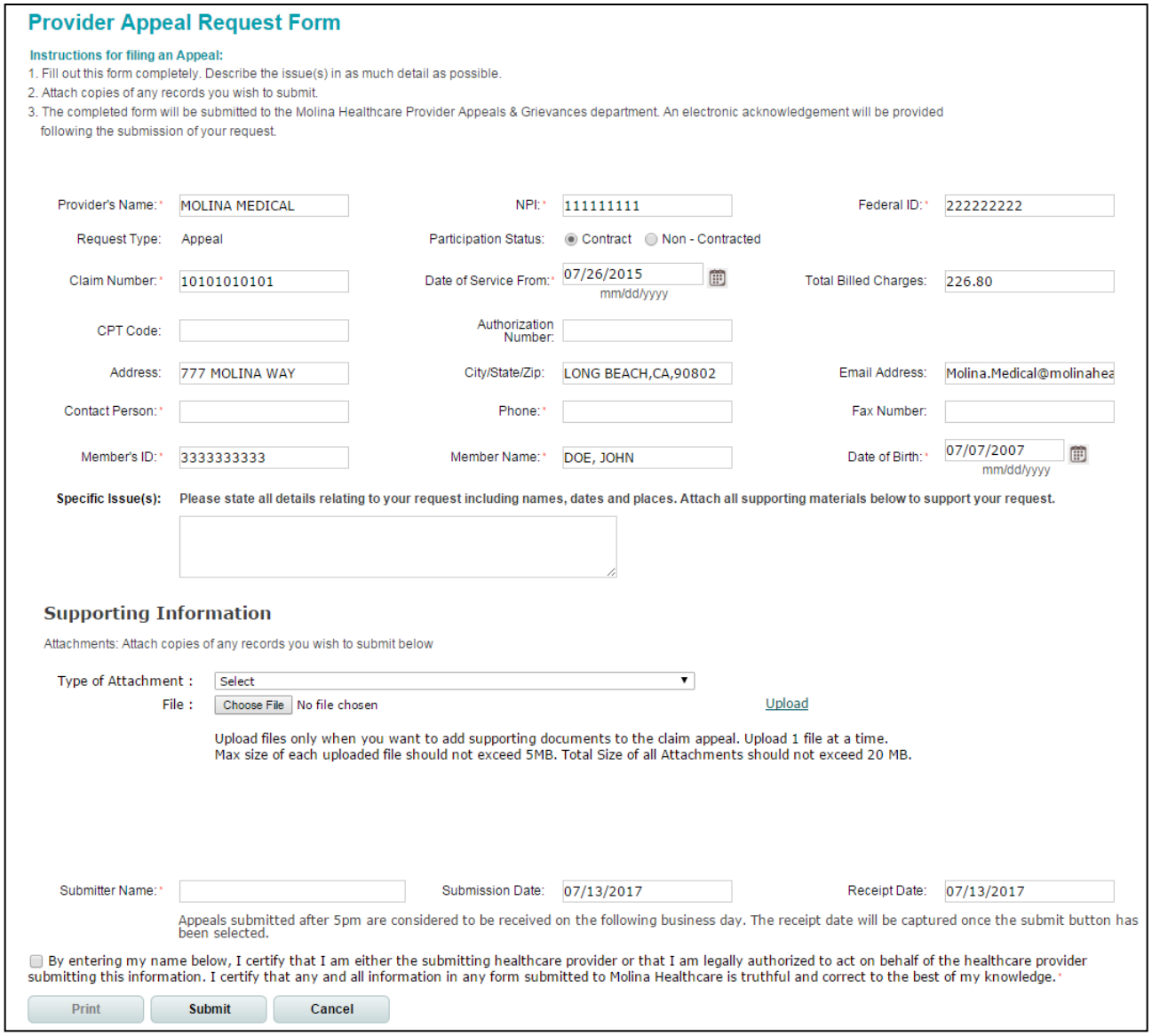


Note: The “Appeal Claim” button is only available for finalized (paid, denied, etc.) claims.

Provider Appeal Request Form

The following information will be auto-populated:

- Provider Name
- NPI
- Federal ID
- Claim Number
- Date of Service
- Total Billed Charges
- Address
- City/State/Zip
- Member ID
- Member Name
- Date of Birth
- Submission Date
- Receipt Date



Provider Appeal Request Form

Instructions for filing an Appeal:

1. Fill out this form completely. Describe the issue(s) in as much detail as possible.
2. Attach copies of any records you wish to submit.
3. The completed form will be submitted to the Molina Healthcare Provider Appeals & Grievances department. An electronic acknowledgement will be provided following the submission of your request.

Provider's Name:*	MOLINA MEDICAL	NPI:*	111111111	Federal ID:*	222222222
Request Type:	Appeal	Participation Status:	(•) Contract ( ) Non - Contracted		
Claim Number:*	10101010101	Date of Service From:*	07/26/2015 mm/dd/yyyy	Total Billed Charges:	226.80
CPT Code:		Authorization Number:			
Address:	777 MOLINA WAY	City/State/Zip:	LONG BEACH,CA,90802	Email Address:	Molina.Medical@molinahea
Contact Person:*		Phone:*		Fax Number:	
Member's ID:*	3333333333	Member Name:*	DOE, JOHN	Date of Birth:*	07/07/2007 mm/dd/yyyy

Specific Issue(s): Please state all details relating to your request including names, dates and places. Attach all supporting materials below to support your request.

Supporting Information

Attachments: Attach copies of any records you wish to submit below

Type of Attachment : Select

File : Choose File No file chosen Upload

Upload files only when you want to add supporting documents to the claim appeal. Upload 1 file at a time.
Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.

Submitter Name:*		Submission Date:	07/13/2017	Receipt Date:	07/13/2017

Appeals submitted after 5pm are considered to be received on the following business day. The receipt date will be captured once the submit button has been selected.

☐ By entering my name below, I certify that I am either the submitting healthcare provider or that I am legally authorized to act on behalf of the healthcare provider submitting this information. I certify that any and all information in any form submitted to Molina Healthcare is truthful and correct to the best of my knowledge.*

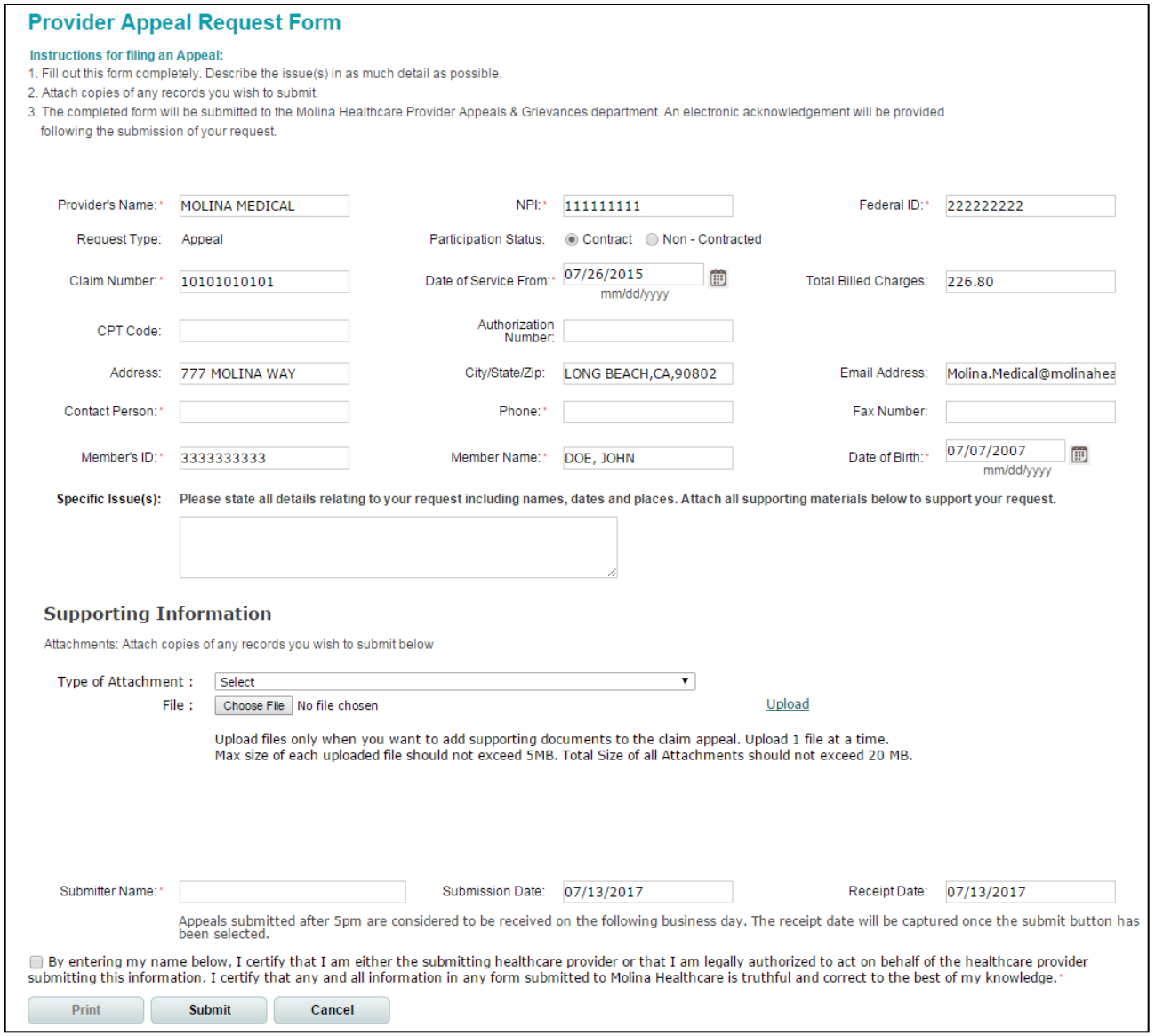
Print Submit Cancel

Provider Appeal Request Form

All populated data can be updated by backspacing and typing the correct information into the field.

All fields with the exception of “Member ID,” “Member Name,” “DOB” and “Email Address” are editable.

The “Submission Date” and “Receipt Date” are populated based on the time zone of the logged in provider. These values are set and cannot be changed.



Provider Appeal Request Form

Instructions for filing an Appeal:
1. Fill out this form completely. Describe the issue(s) in as much detail as possible.
2. Attach copies of any records you wish to submit.
3. The completed form will be submitted to the Molina Healthcare Provider Appeals & Grievances department. An electronic acknowledgement will be provided following the submission of your request.

Provider's Name: * MOLINA MEDICAL
NPI: * 111111111
Federal ID: * 222222222
Request Type: Appeal
Participation Status: Contract / Non - Contracted
Claim Number: * 10101010101
Date of Service From: * 07/26/2015 mm/dd/yyyy
Total Billed Charges: 226.80
CPT Code:
Authorization Number:
Address: 777 MOLINA WAY
City/State/Zip: LONG BEACH,CA,90802
Email Address: Molina.Medical@molinahea
Contact Person: *
Phone: *
Fax Number:
Member's ID: * 3333333333
Member Name: * DOE, JOHN
Date of Birth: * 07/07/2007 mm/dd/yyyy
Specific Issue(s): Please state all details relating to your request including names, dates and places. Attach all supporting materials below to support your request.

Supporting Information

Attachments: Attach copies of any records you wish to submit below

Type of Attachment : Select
File : Choose File No file chosen Upload

Upload files only when you want to add supporting documents to the claim appeal. Upload 1 file at a time.
Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.

Submitter Name: *
Submission Date: 07/13/2017
Receipt Date: 07/13/2017

Appeals submitted after 5pm are considered to be received on the following business day. The receipt date will be captured once the submit button has been selected.

By entering my name below, I certify that I am either the submitting healthcare provider or that I am legally authorized to act on behalf of the healthcare provider submitting this information. I certify that any and all information in any form submitted to Molina Healthcare is truthful and correct to the best of my knowledge. *

Print Submit Cancel

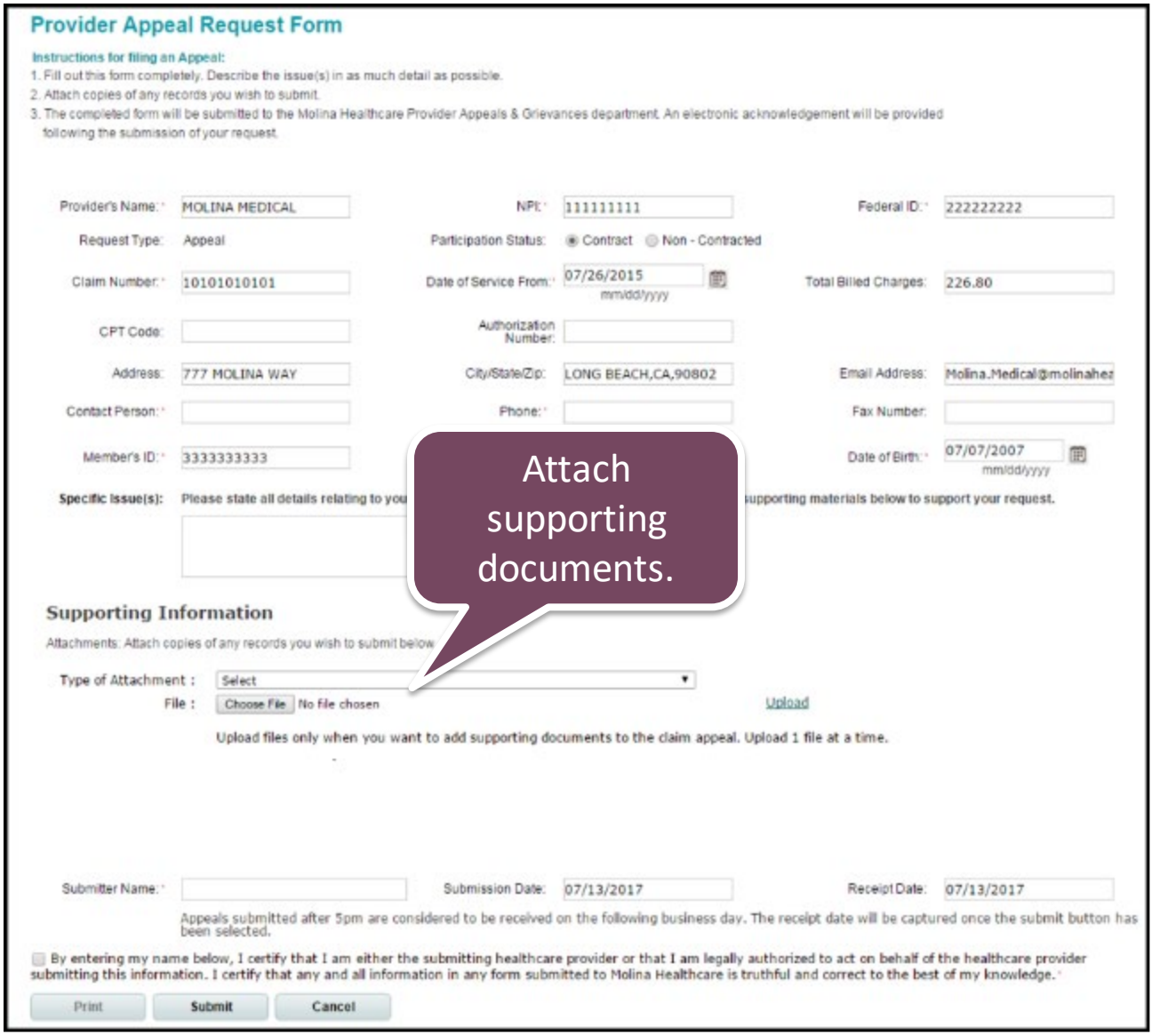
Provider Appeal Request Form

You may attach any supporting documents that are related to the appeal request.

Maximum file size is 125MB for attachments.

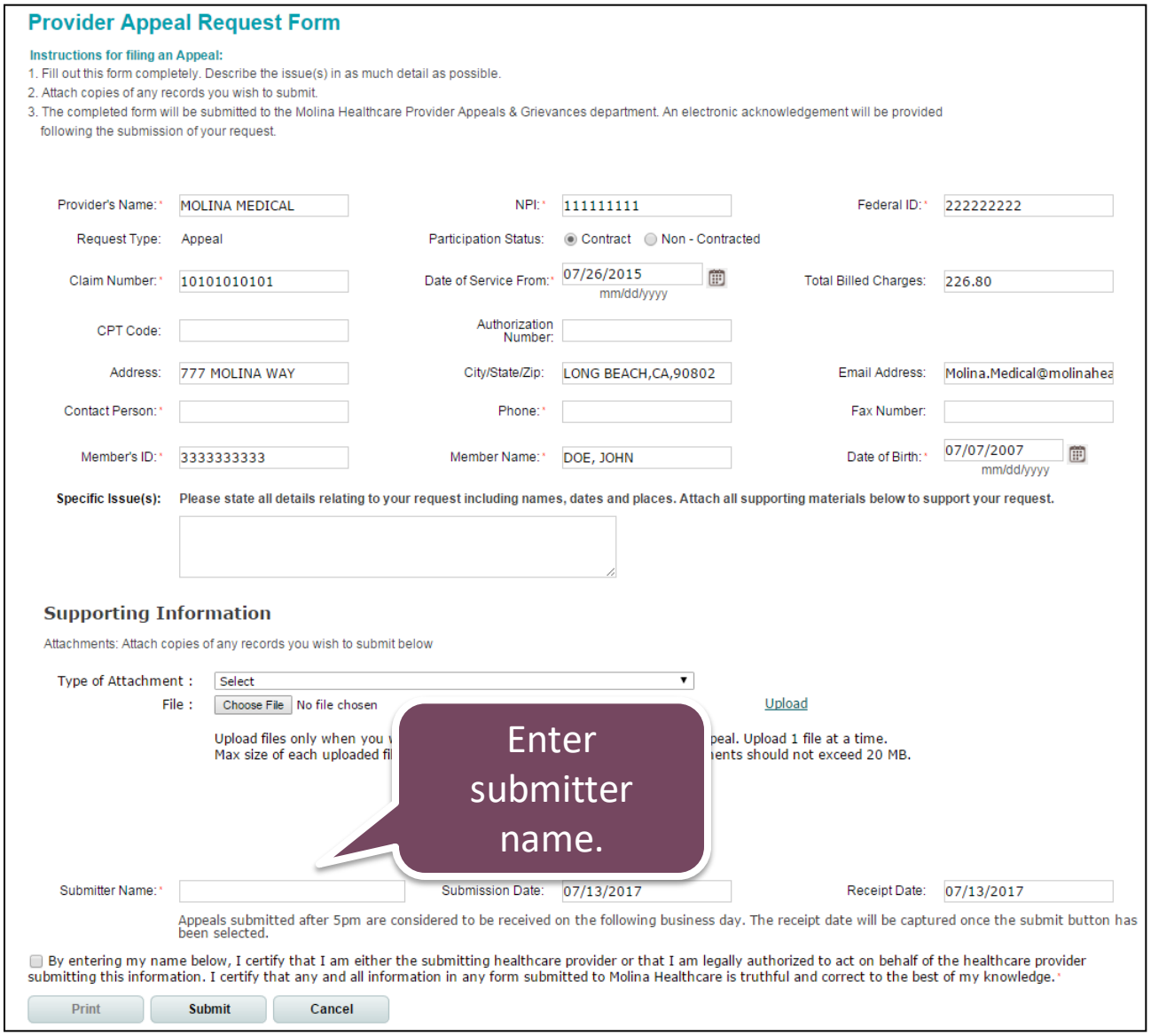
Attachments must be submitted in one of the following formats: *.tif, .gif, .pdf, .bmp, or .jpg.*

Attachments can be uploaded by using the “Supporting Information” section.



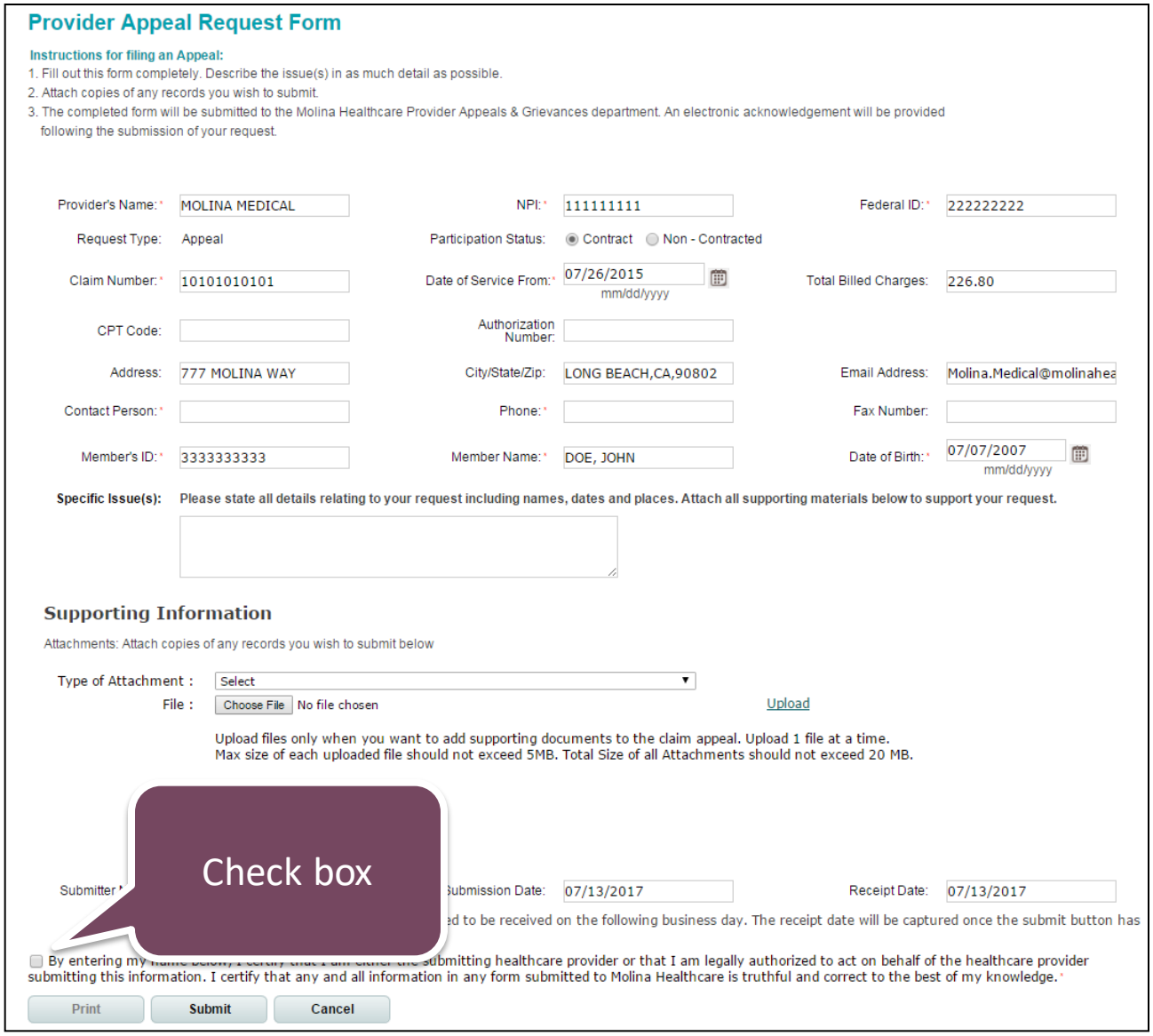
Provider Appeal Request Form

Once all fields have been completed and attachments made, you must agree to the terms and conditions by typing your name into the “Submitter Name” field.



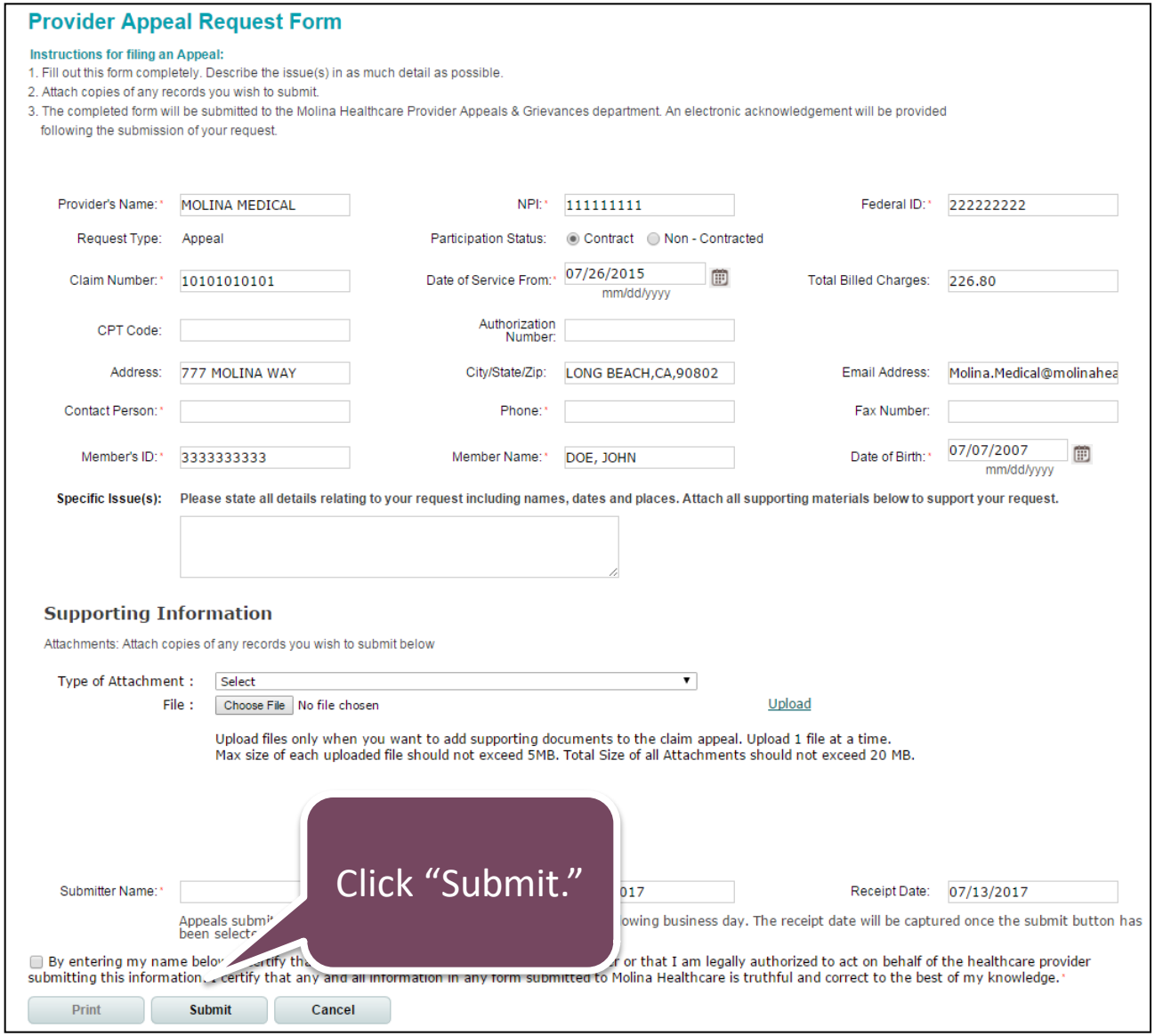
Provider Online Resources

The check box next to the disclaimer at the bottom of the form must also be selected.



Provider Appeal Request Form

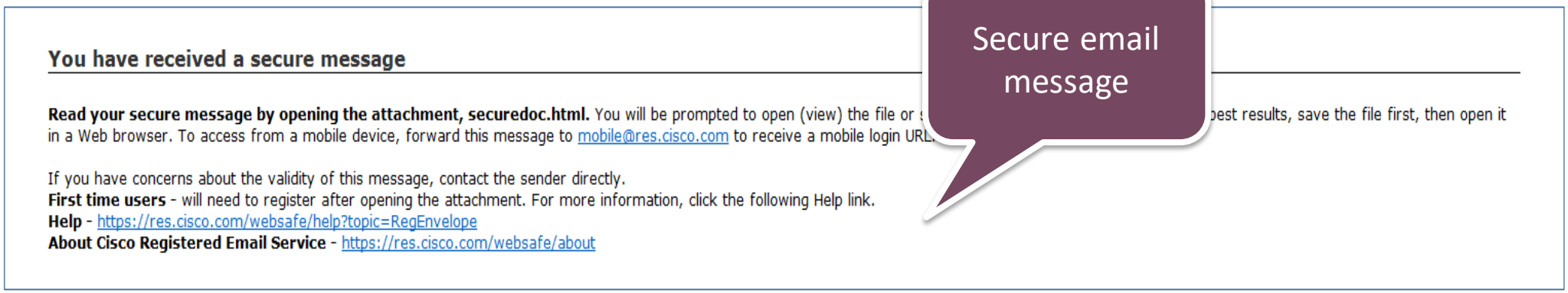
The Provider Appeal request is considered complete once the “Submit” button has been selected at the bottom of the form.



Email Confirmation

Upon submission, you will receive an email confirmation, which serves as an electronic acknowledgement letter.

Upon receipt of the message, you will be prompted to do a one time registration with the provider's email address to view the message. A password will be required for all messages received thereafter.



Commitment to Provider Satisfaction

Molina Healthcare of Ohio is committed to increasing our Provider Partners' satisfaction by obtaining your feedback.

Some of the ways we do this include:

- Dedicated Provider Services Representatives in each region of the state for training and questions
- An annual Provider Satisfaction Survey
- It Matters to Molina program that includes monthly forums and an information page on the Provider Website including surveys for providers to share feedback

It Matters TO MOLINA

Take our "It Matters to Molina Suggestion Box" survey on the It Matters to Molina Page of our Provider Website, under the "Communications" tab.

Your Opinion Matters to Molina

Email us to share your comments, concerns or ideas. Your feedback is important to us. Let us know what we're doing well and what we can do to improve.

Please share your feedback with us so we can continue to provide you with excellent customer service!

Resources

Molina has designated email addresses based on provider types to help get your questions answered more efficiently or to connect you to training opportunities.

- Behavioral Health questions: BHProviderServices@MolinaHealthcare.com
- Hospital or hospital-affiliated physician group questions: OHProvider.ServicesHospital@MolinaHealthcare.com
- MyCare Ohio LTSS and Ancillary questions: OHMyCareLTSS@MolinaHealthcare.com
- Nursing Facilities questions: OHProviderServicesNF@MolinaHealthcare.com
- Physician practice questions: OHProviderServicesPhysician@MolinaHealthcare.com
- General questions: OHProviderRelations@MolinaHealthcare.com

Coordination of Benefits (COB) or Member Enrollment updates:

- Medicaid members MHOEnrollment@MolinaHealthcare.com
- Medicare members MPEnrollmentOH@MolinaHealthcare.com
- MyCare Ohio Opt-In members OHMMP_EnrollmentAccountingMHI@MolinaHealthcare.com
- MyCare Ohio Opt-Out members OptOut.OHMMP@MolinaHealthcare.com