MHWI Appeals and Grievances Processes

2024 | Presented by Molina Healthcare of Wisconsin

MOLINA HEALTHCARE

Molina's Mission & Vision

Our Mission: We improve the health and lives of our members by delivering high-quality health care.

Our Vision: We will distinguish ourselves as the low-cost, most effective, and reliable health plan delivering government-sponsored care.

MOLINA® HEALTHCARE

Agenda

- Provider Feedback: Round Table
- Member appeal submission process
- Member appeal review process
- Provider claim disputes
- Optum process
- Payment process
- Helpful links
- Q & A

Member Appeal Submission Process: Medicaid & Marketplace

MOLINA HEALTHCARE

Medicaid Member Appeal Submission Process

- **When to file:** After an adverse benefit determination (a denial, reduction or partial approval of a service/benefit, or failure to make payment in whole or in part for services received).
  - **Must** be filed within 60 calendar days of the denial.
- If filed by someone other than the Member, the Member **must** give verbal or written consent.
- Members may self-request to appeal by phone or in writing.

Marketplace Member Appeal Submission Process

- **When to file:** After an adverse benefit determination (a denial, reduction or partial approval of a service/benefit, or failure to make payment in whole or in part for services received).
  - **Must** be filed within three years of the denial.
- Appeals must be submitted in writing.
- If filed by someone other than the Member, the Member **must** give written, signed permission.

Medicaid and Marketplace Member Appeal Submission Process

Submit Member Appeals to:

Molina Healthcare of Wisconsin, Inc.
Attn: Member Appeals & Grievances
PO Box 182273
Chattanooga, TN 37422
Fax: (844) 251-1445

Member Appeal Request Requirements

The following information **must** be included with the submission:

- Signed Consent Form for appeal
- Copy of the denial letter
- Member's name
- Member's ID number
- Authorization number
- Service being requested
- Complete medical records
- Supporting clinical information, lab work, why the service is medically necessary
- If request is for testing, how will the information received from test completion inform member's future medical care?

Member Appeal Request Requirements

- Review the Denial Notification and ensure that **all** missing information has been addressed.
- Ensure any additional medical documentation supporting the appeal is included.

Member Appeal Review Processes

MOLINA HEALTHCARE

Member Appeal Review Process—Medicaid and Marketplace

- What qualifies as an Expedited Appeal?
  - Any situation that put the member's health at serious risk if an answer is not given within 72 hours.
- Member resolution time frames:
  - Expedited Appeal: **72 hours** from receipt.
  - Standard Appeal: **30 calendar days** from receipt.
- How is resolution communicated?
  - By phone call to member and provider.
  - By written letter.

Provider Claim Disputes

MOLINA HEALTHCARE

Provider Dispute Submission Process

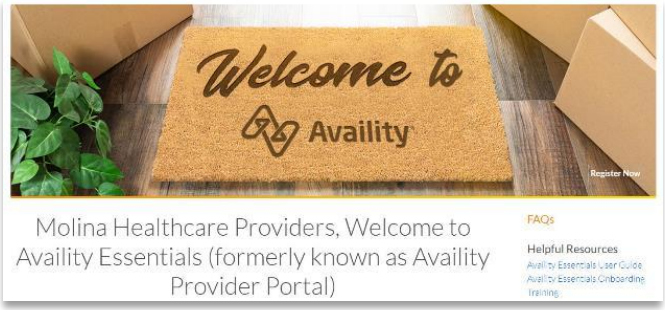
- Provider disputes/appeals **must** be submitted within 90 calendar days from the remittance date.
- Disputes/appeals **must** be submitted in one of the following 3 ways:
  - **Provider Portal (preferred)**: The Availity Essentials Provider Portal can be found at availity.com/molinahealthcare.
  - **Fax**: (855) 251-1446
  - **Email:** MWI.Appeals@MolinaHealthcare.com

Fax and Email Appeals should include a completed appeal request form which can be found on our website.

NOTE: Paper appeals will be rejected and not processed.

Availity Essentials Provider Portal

- Providers no longer have direct access to the Legacy Provider Portal—but you can access all functions via Availity.
- Availity Essentials Portal landing page: availity.com/molinahealthcare
- With technical issues, contact Availity Help Desk at **(800) 282-4548**.
- **NOTE**: You can reach **all** portal functions **via Availity**.



Provider Dispute Submission Process

The following information **must** be included with the submission:

- Provider's name
- Date of service
- Date of billing
- Date of payment and/or nonpayment
- Member's name
- Member's ID

- Claim number (No appeal is excepted without a finalized claim on file)
- The reason(s) the claim merits reconsideration. If the appeal relates to medical emergency, medical necessity, prior authorization, or code edits, medical records or substantiating documentation **must** accompany your request for reconsideration.

Provider Best Practices

Reminders when submitting:

- **Only one (1) claim per submission** on the dispute form.
- Claim denied due to code edit (e.g., bundling/unbundling, like or similar procedure).
  - Provide Medical Records on dispute.
- Inpatient records should contain at a minimum:
  - Physician notes
  - Nurse notes
  - Discharge summary
- Denied for untimely authorization, untimely filing of claim, or dispute:
  - Provide information / verification about why the request was not filed within time frame requirements.

Optum Process

MOLINA HEALTHCARE

Optum Process

- Fall 2020: Molina implemented Optum Pre-Pay Review to ensure services billed are consistent with medical record documentation, in accordance with regulatory and health plan policies, including correct coding guidelines.
- Explanation of payment (EOP) will have edit message showing Optum requesting medical records. A letter is also sent with detailed instructions on how and where to submit medical records.

Optum Process

In addition to the EOP, a corresponding letter would be issued with instructions for submission of the reconsideration. For each claim listed, submit **all** of these documents as applicable:

- Cover sheet with the specific claim number and bar code.
- A copy of the claim form or paper substitute of an electronic claim.
- Complete medical records: history and physical, office/treatment records, consultation reports, operative reports, anesthesia and recovery room records, and discharge summaries.
- Infusion flow sheets or medication administration logs.

(more)

Optum Process

- Orders and results of diagnostic tests, including pathology, radiology, and laboratory.
- For DME, include a signed receipt from the member verifying receipt of any device/equipment/supplies.
- For all drug codes, include the NDC information, drug name, units, provider HRSA grant number and information, along with invoice with the acquisition cost for the individual drugs.
- Itemization of services billed for applicable date(s) of service.
- Optum must receive this information within 30 calendar days from the date of the notice.

Optum Process—Providing Documentation

- The letter you receive from Optum will provide highly detailed instructions on how to provide the required information:
  - Secure internet upload (SFTP)
  - Fax (267) 687-0994.
  - Mail:

Mail (US Postal Service)

Optum on behalf of Molina Healthcare
P.O. Box 51456
Philadelphia, PA 19115

  - FedEx/UPS:

Delivery Services (FedEx, UPS):

Optum on behalf of Molina Healthcare
458 Pike Road
Huntingdon Valley, PA 19006

  - CD/DVD: Refer to your letter.

Optum Process

- If you disagree with denial, you may submit Reconsideration directly to Optum, along with any medical records.
- If you disagree with the Reconsideration, you may submit a formal dispute to Optum.

Optum Process

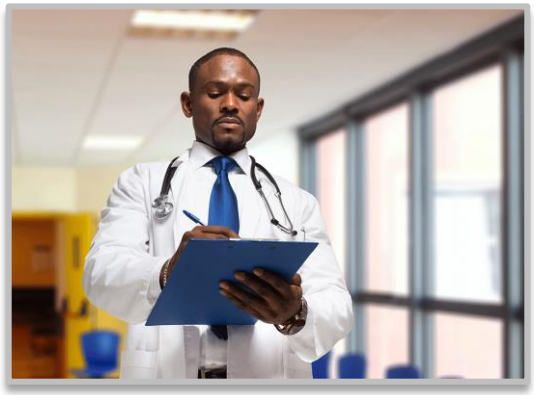
- If you **still** disagree with the Optum formal dispute, then you may submit a dispute to Molina:

  Provider Portal (preferred):
  Welcome to Molina Healthcare, Inc - ePortal Services

  Fax: (855) 251-1446

  Email: MWI.Appeals@MolinaHealthcare.com

  NOTE: Paper appeals will be rejected and not processed.



- **Note**: Timeline for disputing pre-pay decision is 90 calendar days.

Payment Process

MOLINA HEALTHCARE

Sample Explanation of Payment (EOP)

Tax ID: ***EPC Draft #:*** *0* ***Payment Date:*** *08/30/2023* Page 1 of 3

Patient Name:
Subscriber Name:
Carrier Name: N/A
Rendering Provider:

Member ID:
Patient Control #:
NPI #:

Payer Claim Ctrl #:
Payer Check Number:
Policy Number: N/A
Program: Molina Medicare Complete Care

Claim Line	Service From / Service Thru	Proc/Rev / Modifiers	Units	Billed Amount	Allowed Amount	Disallow Amount / Gross Plan Payable	COB Amount / Refund	Other Adjustments / FFS Withhold	Patient Obligation: Co-Ins / Deductible	Patient Obligation: Co-Pay / Non-Cov	Net Plan Payable	FFS CAP	Line Status	Adjustment Reason	Remark
1	03/17/22	80061	0.0	$60.00	$13.39	$46.61	$0.00	$0.00	$2.68	$0.00	$10.71	FFS		CO45 PR2	
	03/17/22	QW				$10.71	$0.00	$0.00	$0.00	$0.00					
2	03/17/22	99497	0.0	$120.00	$81.29	$38.71	$0.00	$0.00	$0.00	$0.00	$81.29	FFS		CO45	
	03/17/22	33				$81.29	$0.00	$0.00	$0.00	$0.00					
3	03/17/22	G0446	0.0	$30.00	$25.11	$4.89	$0.00	$0.00	$0.00	$0.00	$25.11	FFS		CO45	
	03/17/22	59				$25.11	$0.00	$0.00	$0.00	$0.00					
4	03/17/22	G0447	0.0	$30.00	$0.00	$30.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS	DENY	CO16	MA63
	03/17/22	59				$0.00	$0.00	$0.00	$0.00	$0.00					
5	03/17/22	G0296	0.0	$90.00	$27.53	$62.47	$0.00	$0.00	$0.00	$0.00	$27.53	FFS		CO45	
	03/17/22					$27.53	$0.00	$0.00	$0.00	$0.00					
6	03/17/22	99401	0.0	$90.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS	DENY	PR96	N425
	03/17/22	25				$0.00	$0.00	$0.00	$0.00	$90.00					
	Claim Total:			$420.00	$147.32	$182.68	$0.00	$0.00	$2.68	$0.00	$144.64				
						$144.64	$0.00	$0.00	$0.00	$90.00					

***** Msg:**

Adjustment of Claim # 1
Adjusted - Additional information Received

***** Msg:**

Line 4: (NPD) NOT A PRIMARY DIAGNOSIS
Line 6: Statutorily excluded service(s).

Itemized Bill Requests

- High-dollar claims may result in a request for an itemized bill:
  - EOP remit statement: Itemized statement **required** for charge line review.
  - **Availity Portal (Preferred Method) –** availity.com/molinahealthcare
  - Submit itemized statement to:
    - **Paper Claim:**

      Molina Healthcare of Wisconsin, Inc.

      PO Box 22815

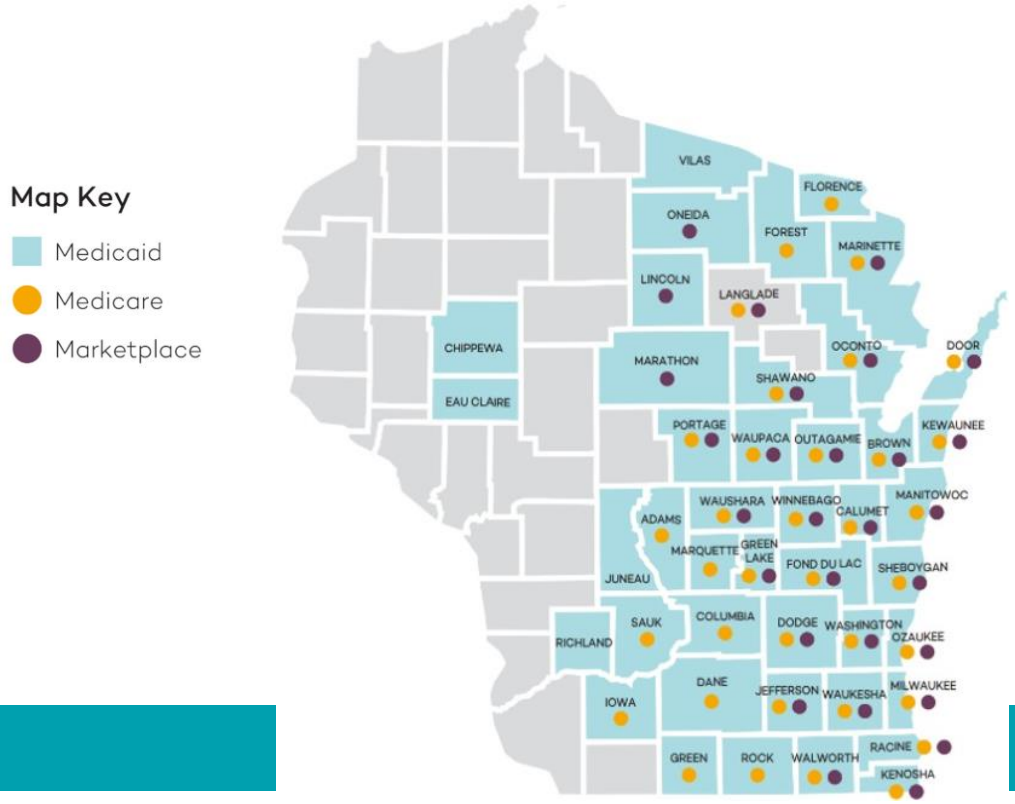
      Long Beach, CA 90801

Helpful Links

- DHS FowardHealth Website: ForwardHealth Portal (wi.gov)
- Molina Website → Provider Bulletins: https://www.molinahealthcare.com/providers/wi/medicaid/Provider-Bulletins.aspx
- Molina Website → Medicaid Provider Manual: Wisconsin Providers Home (molinahealthcare.com)
- Molina Website → Marketplace Provider Manual: Providers (molinamarketplace.com)
- Molina Website → Medicare Provider: Medicare Providers (molinahealthcare.com)
- Availity Provider Portal: availity.com/provider-portal-registration
- Molina Provider Network Management team email: MHWIProviderNetworkManagement@MolinaHealthcare.com
- You Matter to Molina Provider Education Series https://www.molinahealthcare.com/providers/wi/medicaid/comm/YouMattertoMolina.aspx

Your Molina Contacts

- Your **Provider Relations Manager (PRM)** is your liaison to all of Molina's programs and provider services.
- Reach out to our team anytime: MHWIProviderNetworkManagement@MolinaHealthcare.com
- MHWI Service Area:



Thanks for participating!

Register for email updates:
https://www.molinahealthcare.com/providers/wi/medicaid/subscription

MOLINA HEALTHCARE