Molina Healthcare of Wisconsin, Inc. Appeals & Grievances

Molina Medicaid BC+, SSI, and Marketplace

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Agenda

1. Submitting Member Appeals
2. Reviewing Member Appeals
3. Provider Claim Disputes
4. Optum Review Process
5. Resources / Q&A

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Submitting Member Appeals
Medicaid BC+, SSI & Marketplace

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Medicaid BC+ & SSI 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.

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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.

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

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Member Appeal Review Process
Medicaid BC+, SSI & Marketplace

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Member Appeal Review Process
Medicaid BC+, SSI 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
Medicaid BC+, SSI & Marketplace

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Provider Dispute Submission Process

Medicaid BC+, SSI and Marketplace

- 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)**: Availity Essentials Provider Portal
  - **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.

Paper appeals will be rejected and not processed.

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Provider Dispute Submission Process

Medicaid BC+, SSI and Marketplace

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 accepted 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.

Itemized Bill Request

- High-dollar claims may result in a request for an itemized bill:
  - EOP remit statement: Itemized statement **required** for charge line review.
- Itemized Bills can be submitted using:
  - **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

Optum Claim Review Process

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Optum Review Process

If your claim is flagged by Optum for review, your EOP and a corresponding letter will be issued with instructions on how to submit medical records and supporting documentation for reconsideration.

Include the following in your submission:

- 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, anesthesia and recovery room records, and discharge summaries.
- Infusion flow sheets or medication administration logs.

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Optum Review 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.

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Optum Review Process – Sharing Documentation

- The letter you receive from Optum will provide highly detailed instructions on how to submit 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.

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Appealing an Optum Determination

- If you disagree with denial, you may submit Reconsideration directly to Optum, along with additional medical records and/or supporting documentation.
- If you disagree with the Reconsideration, you may submit a formal dispute to Optum.
- If you **still** disagree with the Optum formal dispute, then you may submit a dispute to Molina:
  - **Availity Portal (Preferred Method) –** availity.com/molinahealthcare
  - **Fax:** (855) 251-1446
  - **Email:** MWI.Appeals@MolinaHealthcare.com

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

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Tools & Resources

- DHS FowardHealth Website: **ForwardHealth Portal (wi.gov)**
- Molina Medicaid Provider Manual: **Wisconsin Providers Home (molinahealthcare.com)**
- Molina Marketplace Provider Manual: **Providers (molinamarketplace.com)**
- Availity Essentials Provider Portal: **availity.com/provider-portal-registration**
- Molina Provider Network Management team email: **MHWIProviderNetworkManagement@MolinaHealthcare.com**
- **You Matter to Molina Provider Resources & Education Series**

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Questions?

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