Section 14. Complaints, Grievance and Appeals Process

Molina Healthcare Members or Member's personal representatives have the right to file a complaint, grievance and submit an appeal through a formal process. This section addresses the identification, review and resolution of Member grievances and appeals. Below are Molina Healthcare's Member Grievance and Appeals Process.

Member Complaints, Grievance & Appeals Process

If a Member is unhappy with the service from Molina Healthcare, providers contracted with Molina Healthcare, or its subcontractors, they may file a complaint or a formal grievance by contacting Member Services toll-free at (866) 472-4585, Monday – Friday 8 a.m. – 7 p.m. They can also write to us at:

Molina Healthcare of Florida
Attention: Grievance & Appeals Department
P.O. Box 521838
Miami, FL 33152
Doral, FL 33122

Members may also send their written grievance via fax to (877) 508-5748.

Members are notified of their grievance and appeal rights and the different levels of grievances and appeals through various general communications including, but not limited to, the Member handbook, Member newsletters and Molina Healthcare's web site www.molinahealthcare.com. Members are notified of these rights upon enrollment, and annually thereafter.

Members may identify an individual, including an attorney or provider, to serve as a personal representative to act on their behalf at any stage during the grievance and appeals process. If under applicable law, a person has authority to act on behalf of a Member in making decisions related to health care or is a legal representative of the Member, MHF will treat such person as a personal representative.

The Member/Provider may file a complaint or Grievance within one year (365 days) after the date of occurrence that initiated the grievance. If the Member/Provider registers an informal complaint, Molina Healthcare will attempt to resolve the complaint within 24 hours. If the complaint cannot be resolved, it will be treated as a formal grievance.

The Member/Provider must file an Appeal within thirty (30) calendar days of receipt of the notice of the Health Plan's action.

Members are given reasonable assistance in completing forms and taking other procedural steps, including translation services for Members with limited English proficiency or other limitations, e.g., hearing impaired, requiring communication support.

All grievances whether oral or in writing, and Appeals (oral, followed by written confirmation within 10 days of) are documented by the Member Services Department in all appropriate systems., and written acknowledgement is sent to all parties.

Any issues related to a clinical denial and/or appeal of a coverage decision, is referred to the Utilization Management Department to review the medical necessity aspects of the request.

A person not involved in the previous decision-making process reviews the grievance or appeal to determine the resolution. In appeals involving denial of clinical services, health care professionals with appropriate expertise conduct the review. A Medical Director of same or similar specialty who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination will review the appeal and make the determination.

All grievance and appeal requests concerning admissions, continued stay, immediate care issues, or other services for Members who have received emergency services but have not been discharged from a facility are granted an Expedited Review. Expedited Reviews are completed as promptly as the medical condition requires, but no later than three (3) days after the request.

Any grievance or appeal with Potential Quality of Clinical Care (PQOC) and/or Critical Incidents issues is referred to the Quality Improvement Department for further investigation and handling. Additionally, any identified issue related to the Privacy and Confidentiality of Protected Health Information (PHI) is referred to the Privacy Officer.

All grievance decisions are made within state established time frames not to exceed ninety (90) calendar days from the day the initial grievance or appeal is received. However, the grievance process time-frame may be extended up to fourteen (14) calendar days if the Member voluntarily agrees to an extension. All appeal decisions are made within state established time frames not to exceed thirty (30) calendar days from the day the initial grievance or appeal is received. However, the appeal process time-frame may be extended up to (14) calendar days if the Member voluntarily agrees to an extension

All aspects of the review process are documented and tracked in Molina Healthcare's core data maintenance application and Grievance and Appeal database.

Members also have the right to appear in person and/or appoint a representative to act and speak on the Member's behalf at any point in the grievance and appeals process.

At any point during the grievance and appeal process, Members have the right to request a Medicaid Fair Hearing or an external independent review (IRO). To request a Fair Hearing, Members/Member representative, should contact:

Office of Appeals Hearings
1317 Winewood Blvd.
Bldg. 5 – Room 255
Tallahassee, FL 32399-0700
Phone: 1-850-488-1429
Fax: 1-850-487-0662

If a Member is not satisfied with Molina Healthcare's decision of their grievance or appeal they may request a review by the Beneficiary Assistance Program (BAP). The Member has one year from receipt of the decision letter to request a review. If the Member files a Medicaid Fair Hearing on their case, they forfeit the right to a BAP review of their case. To request a review by BAP, Members/Member representatives should contact:

Agency for Healthcare Administration
Beneficiary Assistance Program
Building 1, MS #26
2727 Mahan Drive
Tallahassee, FL 32308
1-850-412-4502
1-888-419-3456 (toll-free)

Molina Healthcare shall continue the Member's benefits if the Member or the Member's authorized representative submits a request for appeal within ten (10) business days after the notice of the adverse action is mailed, or within ten (10) business days after the intended effective date of the action, whichever is later.

If the final resolution of the appeal is adverse to the Member and the action is upheld, Molina Healthcare may recover the cost of services furnished to the Member while the appeal was pending to the extent they were furnished solely because of the continuation of benefits requirement.

Expedited Appeal

An appeal will be expedited in response to the clinical urgency of the situation; i.e., when a delay would jeopardize a Member's life or materially jeopardize a Member's health. A request to expedite may come from the Member, a provider, or when Molina Healthcare feels it prudent to do so. An expedited appeal will be acted on quickly and a decision made within (3) calendar days.

Reporting

All Grievance/Appeal data, including practitioner specific data, is reported quarterly to Member/Provider Satisfaction Committee (MPSC) by the Department Managers for review and recommendation. A Summary of the results is reported to the Executive Quality Improvement Committee quarterly. Annually, a quantitative/qualitative report will be compiled and presented to 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.

Grievance and Appeals reports will be reviewed monthly by the Credentialing Coordinator for inclusion in the trending of ongoing sanctions, complaints and quality issues. Appeals and Grievances will be reported to the State quarterly.

Record Retention

Molina Healthcare will maintain all grievance and related appeal documentation on file for a minimum of six (6) years. In addition to the information documented electronically in Molina Healthcare's core processing system or maintained in other electronic files, Molina Healthcare will retain copies of any written documentation submitted by the provider pertaining to the grievance/appeal process.