Medicaid Authorization Appeal, Clinical and Non-Clinical Claim Dispute Guide

Authorization Appeals, Clinical Claim Disputes and Non-Clinical Claim Disputes

This guide was created to break down the differences between a Peer-to-Peer review, an Authorization Appeal, a Clinical or Non-Clinical Claim Dispute, a Member Appeal represented by the provider, and an External Medical Review. The requirements for each process are included below. Please consult your contractual agreement for any exclusions or exceptions.

Definitions

Peer-to-Peer – The provider directing the care of the member requests to speak to a Medical Director regarding an adverse determination and potentially provides additional verbal information. Peer-to-Peer is a conversation.

Authorization Appeal— Formerly known as an "authorization reconsideration." A provider dispute for the denial of a prior authorization. The Authorization Appeal must be submitted pre-claim and within 30 days of the initial authorization denial. The Authorization Appeal should be submitted on the Authorization Reconsideration Form (Authorization Appeal and Clinical Claim Dispute Request Form) and submitted via fax. Decisions will be made within forty-eight hours for urgent requests and within 10 calendar days for all other requests. Once the claim is on file, providers must follow the **Clinical Claim Dispute** process.

Clinical Claim Dispute— Formerly known as an "authorization reconsideration." A post-claim provider dispute for the denial of a prior authorization or for the denial of a retro-authorization for Extenuating Circumstances. The Clinical Claim Dispute must be submitted on the Authorization Reconsideration Form (Authorization Appeal and Clinical Claim Dispute Request Form). The Clinical Claim Dispute must be post-claim and submitted within 365 days of the date of service or 60 days from the remittance advice; whichever is later. Providers may submit a Clinical Claim Dispute via the Availity Essentials Portal, fax, or verbally. Decisions will be made within 30 business days.

Retro-Authorization for Extenuating Circumstances – A retro-authorization is a request for an initial medical necessity determination after the services have already been provided to the member. Molina Healthcare allows a retro-authorization request when there are approved, documented, Extenuating Circumstances that prevented the provider from requesting a prior authorization. (See list of approved Extenuating Circumstances below). A retro-authorization should be submitted through the Authorization Appeal process if the claim has not been filed for the services. If a claim has been submitted, providers should request the retro-authorization following the Clinical Claim Dispute process. This is considered the initial medical necessity determination, and if an adverse determination is made, the provider has a dispute right for this decision. The dispute right will follow the same intake process based on the pre- or post-claim status of the services. Providers must use their dispute prior to being eligible for an External Medical Review.

To dispute an adverse determination of a retro-authorization for Extenuating Circumstances review, providers may either file the dispute through the Authorization Appeal process (if no

claim has been filed) or through the Clinical Claim Dispute process (if the claim has already been filed). There is no change to the standard process for filing a dispute.

Example Scenarios:

- If there is no claim on file, the retro-authorization for Extenuating Circumstances and a subsequent dispute can both go through the Authorization Appeal intake process.
- If there is a claim on file after the initial retro-authorization for Extenuating Circumstances request, the dispute follows the Clinical Claim Dispute process.
- If there is a claim on file before the request for an initial review of a retro-authorization for Extenuating Circumstances, both the initial request and the dispute would be submitted through the Clinical Claim Dispute intake process.

External Medical Review – After exhausting Molina's Authorization Appeal or Clinical Claim Dispute process, a provider may request an External Medical Review (EMR) if the authorization or claim denial, limitation, reduction, suspension, or termination was based on medical necessity. For more information on EMR, please see the Utilization Management section of the Provider Manual.

Non-Clinical Claim Dispute— Formerly known as a "claim reconsideration." This process is used only for disputing a payment denial, payment amount, or a code edit. The Non-Clinical Claim Dispute must be submitted on the Claim Reconsideration Form (Non-Clinical Claim Dispute Form). The Non-Clinical Claim Dispute must be post-claim and submitted within 365 days of the date of service or 60 days from the remittance advice; whichever is later. Providers may submit a Non-Clinical Claim Dispute via the Availity Essentials Portal, fax, or verbally by calling the Provider Services Contact Center. Decisions will be made within 15 business days, or with continued communication if Molina needs more time to address the dispute.

Peer-to-Peer Review Process

Network providers may request a Peer-to-Peer (P2P) review within five calendar days of the date of the initial authorization denial notification.

To make the Peer-to-Peer request:

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

If the Peer-to-Peer does not change the outcome of a determination or is not requested within five days, providers may request an Authorization Appeal within 30 days of the date on the authorization denial notification prior to claim submission. Or the provider may request a Clinical Claim Dispute after the claim is submitted. Clinical Claim Disputes must be submitted within 365 days of the date of service or 60 days of the remittance date, whichever is later.

The Authorization Appeal or the Clinical Claim Dispute must include new/additional clinical information to be considered.

Note: Providers can choose to file the Authorization Appeal pre-claim or the Clinical Claim Dispute post-claim, but they cannot submit both.

Authorization Appeal/Clinical Claim Dispute Process

Submit an Authorization Appeal or Clinical Claim Dispute only when disputing a level of care determination, a medical necessity denial with new/additional clinical information, or a retro authorization for Extenuating Circumstances.

Below is the list of Extenuating Circumstances that apply to both inpatient and outpatient authorization requirements. Within 365 days of the date of service or 60 days of the claim denial, whichever is later, the provider may file for a Clinical Claim Dispute even if the authorization was not requested in advance of the service(s) being provided. The specific circumstance the provider feels applied to the request should be noted on the dispute form, documentation to support the extenuating circumstance, as well as the applicable clinical information, should be included with the request. In accordance with Molina policy, please remember to always verify enrollment using the Ohio Department of Medicaid (ODM) Provider Network Management (PNM) module.

Extenuating Circumstances:

- A newborn remains an inpatient longer than the member and needs a separate authorization.
- Member was brought into facility unconscious and/or unable to provide insurance carrier information. (Requires provider to submit copy of registration face sheet and full description of why the documentation could not be obtained from the member. In addition, Molina will review claims/authorizations history for the past six months for validation purposes).
- Retro-enrollment/retro coordination of benefits (COB) change makes Molina the primary carrier.
- Transition of Care/Continuity of Care.
- Abortion/Sterilization/Hysterectomy (operative reports are required).
- The service is not an included benefit in the primary insurance coverage (example: no maternity care benefits).
- A baby is born to a member with other third party primary coverage and the baby is not covered under such coverage.
- Add-on codes, or changes in coding during the procedure (operative reports are required as applicable).
- Other circumstances as determined by Molina.

Dispute Submission Process

Disputes may be submitted via the Availity Essentials Portal, fax, mail, or verbally by calling Molina Provider Services Contact Center.

- A Clinical Claim Dispute or a Non-Clinical Claim Dispute can be submitted via the Availity Essentials Portal, fax, verbally, or by disc through the mail (mail is only accepted if the file size is too large for other submission types).
- As a reminder, an Authorization Appeal is filed pre-claim and must be faxed.

Reminder: When submitting via the Availity Essentials Portal, this action must be completed via the "Appeal Claim" feature.

Access the Availity Essentials Portal at Provider.MolinaHealthcare.com.

For fax submissions, requests must include:

- The Authorization Reconsideration Form (Authorization Appeal and Clinical Claim Dispute Form) filled out entirely with the following details (failure to do so will prevent the form from being processed, and the provider will be notified):
  - Molina-assigned claim number (if applicable)
  - Molina-assigned authorization number
  - Line of business
  - Member name
  - Member ID number
  - Date(s) of service
  - Justification for the dispute/appeal
- Appropriate medical documentation supporting an overturn of the decision. This must be new or additional information to the original request. If this detail is not included, the request will be denied, and no further review will be completed. Only one submission will be accepted. Any additional submissions for the same service will be denied even if it includes new/additional information.
- Disc Submission: Larger files may not be able to process through the Availity Essentials Portal or fax. These large files can be submitted by disc to ensure they are received and processed timely. Follow the policy below when submitting as a disc:
  - Submit one medical record per disc. Those received with more than one medical record will not be processed and the provider will be notified.
  - Complete an Authorization Reconsideration Form (Authorization Appeal and Clinical Claim Dispute Form) (if submitting via fax).
  - If you will be submitting an encrypted disc, please write the password on the completed Authorization Reconsideration Form (Authorization Appeal and Clinical Claim Dispute Form) and indicate that the disc is to follow.
  - If the Authorization Reconsideration Form (Authorization Appeal and Clinical Claim Dispute Form) submission is received with incomplete or missing information, it will not be processed, and the provider will be notified.

- Place the Molina-assigned claim ID number on the disc.
- Discs will not be processed, and the provider will be notified if we cannot access the data.

Mail discs to:
Molina Healthcare of Ohio
Attn: Provider Appeals & Grievances
PO Box 182273
Chattanooga, TN 37422

The Authorization Reconsideration Form (Authorization Appeal and Clinical Claim Dispute Form) can be found on the Molina Provider Website at MolinaHealthcare.com. After following the link, be sure to select the correct line of business at the top of the page before accessing the form.

- When disputing an authorization denial post-claim, submit an Authorization Reconsideration Form (Authorization Appeal and Clinical Claim Dispute Form) with the clinical claim dispute.
- When disputing a claim payment or denial, submit a Request for Claim Reconsideration Form (Non-Clinical Claim Dispute Form).

Reminder: Authorization Appeal or Clinical Claim Disputes submitted via paper mailing will not be processed. Disc submissions through mail are only accepted if the dispute size exceeds the Availity Essentials Portal/fax size limit.

Note: All retro-authorization and Extenuating Circumstances reviews should be sent to Molina following the process you use today.

Member Appeal represented by the Provider

You can ask for one Member Appeal represented by the provider within 60 calendar days of the date on the authorization denial notification. If your patient wants you to appeal on their behalf, your patient **must** tell us this in writing using the Authorized Representative Form posted at MolinaHealthcare.com.

The grid below summarizes your options by type of authorization.

Outpatient			**Inpatient**		
P2P	**Authorization Appeal or Clinical Claim Dispute**	**Provider Represented Member Appeal**	**P2P**	**Authorization Appeal or Clinical Claim Dispute**	**Provider Represented Member Appeal**
Yes	Yes	Yes	Yes	Yes	Yes

Non-Clinical Claim Dispute Process (not related to an Authorization/Medical Necessity Review)

Submit a Request for Claim Reconsideration Form (Non-Clinical Claim Dispute Form) only when disputing a payment denial, payment amount, or a code edit. **As a reminder:** Primary insurance Explanation of Benefits (EOB), corrected claims, and itemized statements are **not** accepted via Non-Clinical Claim Disputes. Please refer to the Corrected Claims submission guidelines in the Provider Manual and the Reference Guide for Supporting Document for Claims on the Provider Website.

A Non-Clinical Claim Dispute must be submitted within 365 days of the date of service or 60 days from the disputed claim remit date, whichever is later.

- Use the Availity Essentials Portal to submit the Non-Clinical Claim Disputes:
  - Access the Availity Essentials Portal at Provider.MolinaHealthcare.com
  - Log in with your User ID and Password
  - Attachments can be included with the dispute request

For more details on the Availity Essentials Portal submission process please visit the Availity Learning Center.

- Alternatively, providers may fax the form and supporting documents to the Provider Appeals & Grievances Team at (800) 499-3406
  - The Request for Claim Reconsideration Form (Non-Clinical Claim Dispute Form) must be filled out entirely and include the following details, or it will not be processed, and the provider will be notified:
    - Molina-assigned claim number
    - Line of business
    - Member name
    - Member ID number
    - Date of service
    - Provider ID/NPI
    - Provider phone and fax
    - Detailed explanation of the appeal
    - Pricing sheet, if disputing payment amount
    - Supporting documents

Find the form at MolinaHealthcare.com under the “Forms” tab. (Paper submissions received by mail will not be processed, and the provider will be notified.) Only one Request for Claim Reconsideration Form (Non-Clinical Claim Dispute Form) submission will be accepted and reviewed per claim. Any additional submissions for the same dispute reason on the same claim will be denied and not subject to review, even if it includes new/additional information.

Note: According to Ohio regulations, healthcare providers are not permitted to balance bill Medicaid members for services or supplies provided. View the "Balance Billing" section of the Provider Manual for additional information.

Date		Action
Effective Date	January 2019	Creation of Medicaid and Marketplace Authorization and Claim Reconsideration Guide
Revision Date	February 2022	Updated: NICU 30-day reconsideration process update due to ProgenyHealth partnership.
Revision Date	April 2022	Updated: New Century Health Peer-to-Peer, Authorization Reconsideration and Retro-Authorization processes updates due to the new partnership.
Revision Date	May 2022	Updated: Formatting and streamlined language.
Revision Date	March 2023	Updated: MITS reference changed to PNM, addition of disputes section. Separated into a Medicaid only document and moved Marketplace information to a new document. Removed: Progeny and New Century Health Authorization Appeal exclusions. Updated: terms to Authorization Appeal, Clinical Claim Dispute, and Non-Clinical Claim Dispute, and included definitions.
Revision Date	May 2023	Updated: Appeals & Grievances address change from Columbus, OH to Chattanooga, TN.