MOLINA HEALTHCARE

Your Extended Family.

FOR NON-CONTRACTED PROVIDERS ONLY

Not applicable to contracted providers

NON-CONTRACTED PROVIDER DISPUTE AND APPEALS PROCESSES

For Post-Service Claim Payment Challenges Following an Initial Organization Determination

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Introduction

Whenever a non-contracted provider claim is denied, contested, or adjusted (claim not paid at 100% of billed charges), Molina Medicare will inform the non-contracted provider in writing of the availability of the claim payment dispute resolution (PDR) and/or claim payment appeal (reconsideration) mechanisms and the procedures for obtaining forms and instructions for filing a non-contracted provider dispute and/or appeal.

This process is available for use by non-contracted providers who disagree with Molina Medicare's initial Organization Determination.

Molina Medicare's dispute and appeals processes ensure that non-contracted provider disputes and appeals are handled in a fast, fair, and cost-effective manner.

Please note: Contracted providers follow state processes and the contracted provider's agreement/contract with Molina Medicare and/or the Molina Medicare state Provider Manual guidelines as appropriate.

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How to Determine if the Case Should be Submitted as a Dispute or an Appeal

Dispute/PDR – Is any decision by Molina Medicare *(*Organization Determination*)* that results in a **full or partial payment** to a non-contracted Medicare provider where the non-contracted provider disagrees with the decision.

1. Where the amount paid for a Medicare-covered service is less than the amount that would have been paid under Original Medicare.
2. Where Molina Medicare paid for a different service or more appropriate code than what was billed. Often referred to as a down-coding of claims.

Examples: Bundling issues, disputed rate of payment, Diagnostic Related Groups (DRG) payment dispute, and down-coding.

Appeal/Reconsideration – An appeal is a formal complaint related to denial of a claim by Molina Medicare (adverse Organization Determination) and can be for:

1. Denials that result in **zero payments** to the non-contracted provider.
2. Medical necessity determinations.
3. Appeals for which no initial determination has been made.
4. Local and national coverage determinations.

Examples: Benefit determinations, medical necessity issues, and coverage issues related to national and/or local coverage determination policies (NCDs/LCDs).

Submission Guidelines for Non-Contracted Provider Disputes and Appeals

Please make note the following in order to avoid delays in processing:

Incomplete submissions will affect processing.

Include supporting documentation.

For an appeal the non-contracted provider MUST sign and submit a Waiver of Liability (WOL) Statement before Molina Medicare can begin processing the appeal. If a WOL is not received, the appeal will be forwarded to MAXIMUS Federal Services, Inc. to request a dismissal. A signed WOL is not needed for disputes.

Corrected claims should NOT be submitted as a dispute or appeal. They are considered a **new claim** and should be sent to Molina Medicare's Claims Department for an **initial Organization Determination** and not processed as a dispute or appeal. New claims should be mailed to: MOLINA MEDICARE CLAIMS; P.O. Box 22811; Long, Beach, CA 90801

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Basic Information Needed

Non-Contracted Provider Information

- Non-Contracted Provider's Name
- Non-Contracted Provider's Tax ID # / Medicare ID #
- Non-Contracted Provider's Address
- Non-Contracted Provider Type (specify type – MD, Hospital, Ambulance, DME, etc.)
- Non-Contracted Provider's Contact Name
- Non-Contracted Provider's Contact Title
- Non-Contracted Provider's Contact Phone #
- Non-Contracted Provider's Contact Fax #

Member Information

- Patient's Name (first, middle, last)
- Patient's Date of Birth
- Health Plan Name (Molina Medicare Options (HMO), Molina Medicare Options Plus (HMO SNP), Healthy Advantage (HMO SNP)
- Health Plan ID #
- Patient's Account / ID #

Claim Information

- Original Claim #
- Dates of Service (From/To)
- Original Claim Amount Billed
- Original Claim Amount Paid

Dispute/Appeal Type	Required Documentation
Rate/Fee Dispute – dispute request for a claim that was paid or denied at an incorrect fee.	Copy of Medicare fee schedule in effect during the dates of service. Copy of claim
Coding Edit Revise – request for a claim that was denied or adjusted for CCI edit or bundling.	Appropriate supporting documentation, i.e., OP report, path report Letter stating rational for complication Copy of claim
Medical Necessity/Utilization Management Decision – request for a claim that was denied on initial medical necessity review.	Appropriate medical records, i.e., ER records, H&P, discharge summary (no NOT send daily notes unless requested) Rational for service performed Copy of claim
Other	Copy of claim and supporting documentation

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State Address for Submitting a Non-Contracted Provider Dispute or Appeal

Non-contracted providers must mail a written request to Molina Medicare's state-level Provider Dispute and Appeals Unit:

P.O. Box 22817; Long Beach, CA 90801

Clearly indicate whether you are submitting a dispute (when full or partial payment was made on the initial Organization Determination) or an appeal (when zero payment was initially made).

Deadlines for Submitting Non-Contracted Provider Disputes and Appeals

Dispute/PDR – Non-contracted providers have ***120 calendar days*** from the initial Organization Determination date (i.e., EOB/RA/determination letter) to file a written request for a dispute with Molina Medicare.

Appeal/Reconsideration – Non-contracted providers have ***60 calendar days*** from the initial adverse Organization Determination date (i.e. EOB/RA/determination letter) to file a written request for an appeal with Molina Medicare.

Acknowledgment of Non-Contracted Provider Disputes and Appeals

Molina Medicare will mail an acknowledgement letter to the non-contracted provider within 5 calendar days of receipt.

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Resolution Timeframe for Non-Contracted Provider Disputes and Appeals

Molina Medicare will resolve each non-contracted provider claim payment dispute (PDR) within ***30 calendar days*** of receipt of the written request. Claim payment appeals will be resolved within ***60 calendar days*** of receipt.

Non-Contracted Provider Second Level Independent Review Entity Process

Appeal/Reconsideration – If Molina Medicare upholds the initial claim decision, Medicare requires that Molina Medicare send all cases where we have not changed our decision to an independent review entity. MAXIMUS Federal Services, Inc. is the independent review entity that Medicare uses to review cases to make sure that we made the right decision. After receiving the case file, MAXIMUS Federal Services, Inc. will contact the non-contracted provider to advise where to send any additional information and about other rights that the non-contracted provider may have.