MyCare Ohio and Medicare Authorization and Claim Reconsideration Guide

Pre-Service and Post-Service Authorization Reconsiderations

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

Peer-to-Peer Review Process

Network providers may request a Peer-to-Peer review (P2P) within five calendar days of the date on the initial authorization non-approval notification, or within five calendar days of the date of discharge from the hospital.

To make the Peer-to-Peer request*:

- Call Molina Healthcare Utilization Management at (855) 322-4079 from 8:30 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 reconsideration within 30 days of the date on the authorization non-approval notification, or until the claim is processed.

The authorization reconsideration must include new/additional clinical information to be considered for inpatient services only. Once a determination has been rendered for the authorization reconsideration, no further authorization reconsiderations are available.

*Due to regulatory requirements, for outpatient decisions, a P2P is a consultation only. A determination cannot be overturned via the P2P process.

Inpatient Only: Authorization Reconsideration Process

(Due to regulatory requirements, for outpatient decisions, an authorization reconsideration is not available. Please refer to member appeal rights noted below.)

A P2P can be requested and completed by a provider representing the hospital while a member is hospitalized or within five calendar days of discharge from the hospital.

Submit an authorization reconsideration 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 120 days of the claim denial, the provider may file for an authorization reconsideration even if the authorization was not requested in advance of the service(s) being provided. The specific circumstance the provider

feels was applicable to the request should be noted on the reconsideration 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 Medicaid Program's Eligibility System (MITS).

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.

An Authorization Reconsideration can be submitted via the Provider Portal (only if a claim has been filed) or fax within 30 calendar days of the date on the authorization non-approval notification or until the claim is processed.

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

Instructions for Provider Portal submissions (if a claim has been filed):

1. Access the Provider Portal at Provider.MolinaHealthcare.com
2. Log in with your User ID and Password

For more details please find our Claim Features training on our Provider Website under the "Manual" tab.

For fax submissions, requests must include:

- The Authorization Reconsideration 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 reconsideration
  - If sending an encrypted disc, provide your password on the Authorization Reconsideration Form
- 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.
- Disc Submission: Larger files may not be able to process through the Provider 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 (if submitting via fax).
  - If you will be submitting an encrypted disc, please write the password on the completed Authorization Reconsideration Form and indicate that the disc is to follow.
  - If the Authorization Reconsideration 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 Inquiry Research and Resolution
    P.O. Box 349020
    Columbus, OH 43234-9020

The Authorization Reconsideration Form can be found on the Molina Provider Website 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.

Reminder: Authorization Reconsiderations submitted via paper mailing will not be processed.

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 located at MolinaHealthcare.com, under the Forms tab.

The grid below summarizes your options by type of authorization and by line of business.

	Outpatient			Inpatient		
	P2P	**Authorization Reconsideration**	**Provider Rep. Member Appeal**	**P2P**	**Authorization Reconsideration**	**Provider Rep. Member Appeal**
Medicaid/ Marketplace	Yes	Yes	Yes	Yes	Yes	Yes
Medicare/ MyCare Ohio	Yes*	No	Yes	Yes	Yes	Yes

*As noted above, due to regulatory requirements, for outpatient decisions, a P2P is a consultation only. A determination cannot be overturned via the P2P process.

Claim Reconsideration Process (not related to an Authorization/ Medical Necessity Review)

Submit claim reconsiderations 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 claim reconsideration. 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 claim reconsideration must be submitted within 120 calendar days from the disputed claim remit date.

- Use the Provider Portal to submit the reconsideration.
  - Access the Provider Portal at Provider.MolinaHealthcare.com
  - Log in with your User ID and Password
  - Attachments can be included with the reconsideration request

For more details please find our Claim Features training on our Provider Website under the “Manual” tab.

- Alternatively, providers may fax the form and supporting documents to the Provider Resolution Team at (800) 499-3406.

- The Claim Reconsideration Request Form (CRRF) 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 claim reconsideration 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, health care 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.

Definitions

Authorization Reconsideration – Accepted by Molina within 30 days from the non-approval notification date or prior to discharge of an inpatient (IP) stay of an adverse determination when new clinical information is provided (IP applies to Medicare only). This is reviewed by a Medical Director other than the Medical Director who did the initial review or Peer-to-Peer review.

Claim Reconsideration – Submitted post-claim due to an adverse payment determination, or any other claims dispute. This does not apply to authorization/clinical denials.

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.

Date		Action
Effective Date	Jan. 1, 2019	Creation of Medicaid and Marketplace Authorization and Claim Reconsideration Guide

Revision Date	Feb. 1, 2022	Updated: Formatting and streamlined language. Updated language to note P2P is only available on initial authorization. Clarified language that only one claim reconsideration will be accepted per claim.
Revision Date	May 10, 2022	Updated: Formatting and streamlined language. Updated language to note P2P is available within five calendar days of the date of discharge from the hospital.