

Utilization Management Program

The Utilization Management (UM) Program facilitates quality, cost-effective and medically appropriate services across a continuum of care that integrates a range of services appropriate to meet individual member needs. Services include:

- Preservice and admission review;
- Concurrent review;
- Transitional care;
- Discharge planning;
- Continuity and coordination of member care post hospital discharge;
- After Hours availability (On Call Program);
- Retrospective review;
- Medical case management for specific conditions and specialized clinical programs;
- Clinical policy and criteria development;
- Provider appeal processing;
- Utilization data analysis including monitoring for over and underutilization;
- Evaluating member and provider satisfaction; and,
- Staff education and quality oversight.

Our UM staff is available to meet with you, your office staff and/or your physician group to address your concerns and provide education about our programs. If you have any questions, please contact our UM Department. Contact information:

Molina Healthcare Michigan – Utilization Management Department Services
Phone: 855-322-4077
Fax: 800-594-7404

Business Hours: Monday – Friday (excluding holidays) – 8:30 am – 5:00 pm
After normal business hours: Monday – Friday 5:00 pm – 8:30 am
Saturday, Sunday and holidays

Visit our website for updates, frequently used forms, and professional resources.

www.molinahealthcare.com

Roles

UM Activities are coordinated and conducted under the direction of the Medical Director(s) (Physicians) and the Vice President of Health Care Services.

- Managers
 - Registered Nurses (RN) and Supervisors (RN) oversee the daily functions.

Utilization Management Program

- Multidisciplinary teams are assigned to a population of members divided by geographic area and/or provider group. The teams are comprised of:
 - Complex Case Managers (RN)
 - Clinical Case Managers (RN)
 - Utilization Management Specialists (Licensed Practical Nurses (LPN))
 - Utilization Management Coordinators
- The team structure promotes ownership and accountability to providers and members.
 - An RN is assigned to a lead to coordinate work, perform planning and monitor team functions.
 - Productivity reporting and expectations are monitored.
- Medical Director Physician Support includes:
 - Biweekly case review with teams.
 - Case discussion of complex or chronic illness case management cases
 - Case discussion of members with frequent emergency department (ED) use.
 - Review of cases that cannot be approved by a nurse.
 - Development of criteria/guidelines.
- Pharmacist Support
- Nurse Advice Line (NAL) and On-Call (RN) staff provide clinical availability after normal business hours.
- Health Services Support includes:
 - Medical Social Worker (MSW)
 - Registered Health Information Administrator (RHIA)
 - Healthcare Data Analysts
 - UM Clinical Trainer
 - Quality Nurse Reviewers (RN)
 - Administrative and Clerical Support

Responsibilities

- Preservice and admission review
- Concurrent Review
- Facilitate care transitions
- Discharge planning
- Continuity and coordination of member care
- Case Management
- Retrospective review
- Clinical policy and criteria development
- Provider appeal processing
- Utilization data analysis including monitoring for over and under utilization
- Evaluate member and provider satisfaction with the UM program
- Staff education and oversight

Utilization Management Program

Preservice and Admission Review/Authorization Requirements

Determining Services that Require Authorization

The Molina Healthcare/Molina Medicare Prior Authorization/Pre-Service Review Guide can be found on the Molina Healthcare website at www.molinahealthcare.com. The Molina Healthcare/Molina Medicare Prior Authorization/Pre-Service Review Guide pertains to Molina Healthcare of Michigan Medicaid, Healthy Michigan Plan and MIChild membership.

Examples of services requiring authorization:

- Scheduled outpatient services requiring authorization
- Select ambulatory surgical/diagnostic procedures
- Potentially cosmetic/experimental procedures
- Medical benefit review
- Home health care (Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) – only a MIChild covered benefit).
- Home intravenous (IV) infusion
- Authorization is required for all inpatient admissions
- Molina Healthcare utilizes InterQual® criteria to determine medical necessity.

Determining if a referral should be issued

A referral is a request by a Primary Care Physician (PCP) for a member to receive specialty services from another physician, another health care professional or a facility. PCPs are able to refer a member to a provider/specialist for consultation without submitting an authorization request to Molina Healthcare.

Specialty Network Access (SNA)

The Michigan Department of Community Health, the Medicaid Health Plans and the four public entities: University of Michigan Health System, Wayne State University, Hurley Medical Center and Michigan State University, have worked on joint initiatives to increase access to specialty care services to Michigan Medicaid recipients. We have developed a process to allow Medicaid beneficiaries access to the specialty care services that are unavailable through the Health Plan's contracted network.

Please be advised that Molina Healthcare has a contract with one of the above providers (Wayne State University). Our provider network is robust and contains specialists able to meet your needs. We strongly encourage you to utilize Molina's Provider Network for specialty care.

However, if you determine that a specialist referral is needed for a member to access a specialty care service at one of the above Public Entities that is not available within our network, please contact our UM Department at 855-322-4077 and we will assist you with obtaining a referral to a appropriate affiliated specialty care provider of the four (4) Public Entities. A referral is not necessary for Wayne State University.

Utilization Management Program

When calling, please have patient demographic information, primary care provider and referring specialty information available. Also please have all pertinent information regarding the service being requested and the patient's medical information, including but not limited to specialty required, number of visits, start and end date and diagnosis to facilitate appointment scheduling.

It is our hope that this process will increase the care and access to necessary specialty care to the Michigan Medicaid program beneficiaries. If you have any questions, please contact Molina Healthcare Provider Services at 855-322-4077.

Requesting a Preservice or Admission Review

There are four (3) ways to request a preservice or admission review:

- Electronically
 - Clear Coverage
To improve the prior authorization process for our providers, Molina Healthcare of Michigan has implemented Clear Coverage, a web-based application that can be access through the Molina WebPortal.

As a Molina Healthcare provider, you are able to enter a prior authorization service request and receive automatic authorization for specific services. The process includes an interactive medical review based on Molina Healthcare specific guidelines and InterQual® clinical criteria. You also can upload medical records as needed, verify member eligibility and benefits, view authorization status, and print proof of authorization.

Clear Coverage is available to our entire network

- WebPortal Authorizations
- Fax
Fax your authorization request, and clinical information if required, to the UM Department at 800-594-7404. PCPs/Specialists should use the Molina Healthcare Service Request Form or the Michigan Healthcare Referral Form. You may locate the forms at molinahealthcare.com.
- Telephone
The UM Department can be reached at 855-322-4077.

Urgent Requests

All urgent requests must be submitted by calling the UM department at 855-322-4077. Make sure you identify the request as “urgent” to expedite the review process.

Requesting Authorizations for Services you Weren't Aware Required Authorization or the Authorization was not obtained

There are four (3) ways to request a preservice or admission review:

- Electronically
 - WebPortal Authorizations
- Fax

Utilization Management Program

Fax your authorization request, and clinical information if required, to the UM Department at 800-594-7404. PCPs/Specialists should use the Molina Healthcare Service Request Form or the Michigan Healthcare Referral Form. You may locate the forms at molinahealthcare.com.

- Telephone
The UM Department can be reached at 855-322-4077

Notification of our decision will be given within 14 days of the receipt of the request.

Tips to Help Expedite Authorization Decisions

- Submit your authorizations electronically (Clear Coverage or WebPortal)
- Verify the member's eligibility and benefits
- Accurately complete one of the authorization request forms (Molina Healthcare Service Request Form or the Michigan Healthcare Referral Form)
- Include all appropriate codes (diagnosis code(s) and procedure/item code(s))
- Submit your requests at least 14 days prior for elective services
- Refer to the Molina Healthcare/Molina Medicare Prior Authorization/Pre-Service Review Guide, since many services may not require you to submit an authorization request.
- Include pertinent clinical information (progress notes, lab results, photos, imaging studies)
- Visit molinahealthcare.com for any changes regarding the authorization process

Requesting an Elective Admission

For all elective admissions, the PCP, specialist, or facility must request authorization prior to the scheduled admission. Authorizations may be requested by phone, fax or WebPortal. Please include the following information:

- Member's name, Medicaid beneficiary ID#, date of birth, and age
- Admission date
- Name of admitting facility and fax number
- Diagnosis and Procedure Codes
- Member's current medical condition including date of onset, duration of symptoms, and treatment rendered to date
- Proposed treatment plan
- Requesting physician's fax number
- Pertinent clinical documentation (progress notes, x-ray reports, lab results).

Molina's Process after Provider Submits Authorization

- Molina Healthcare confirms the member's eligibility, benefits and provider's affiliation status.
- If the request is submitted with complete and accurate information, if appropriate, the request is reviewed against medical appropriateness criteria. The criteria sources used are one or more of the following:

Utilization Management Program

- Applicable Federal or State mandates and guidelines
 - McKesson InterQual® Criteria
 - The Hayes Directory for New Medical Technologies
 - Internally developed medical necessity criteria
 - **Algorithms and guidelines from recognized professional societies**
 - Advice from authoritative review articles and textbooks
- If the request does not meet criteria, the UM staff will contact (via telephone, fax, and/or mail) the requestor for clarification or additional clinical information, or refer the case to a Molina Healthcare Medical Director. In the case of a pharmacy request the case may be referred to a Molina Healthcare Registered Pharmacist.

How will you be notified of your decision?

The decision timeframe is based upon the date on which we receive your request and the supporting clinical information. To ensure a timely decision, please provide all supporting clinical information with the initial request. We will contact you when additional clinical or clarifying information is needed. Our decisions are made in accordance with regulatory and accreditation guidelines.

Urgent Approved Requests

We will call the authorization number of the requestor and facility (if indicated) within 72 hours of the initial request.

Non Urgent Approved Requests

We will call or fax the authorization number of the PCP, requesting physician or facility (if indicated) within 14v days of the initial request.

Urgent Denied Requests

The denial rationale for denial and the appeals process will be called to the requesting provider and written notification will be mailed to the member, provider, PCP, and facility (if indicated) within 14 days of the initial request.

Note: Providers may review the UM criteria at Molina Healthcare or they may request a copy of the criteria of interest by telephone, fax, or email.

A Molina Healthcare Medical Director is available to discuss the denial decision with any treating practitioner.

Utilization Management Program

Authorization Submission Guidelines for Dual Eligible Members

For services rendered to patients who are covered by both Molina Medicare Options Plus and Molina Medicaid, **submit one authorization request** – Molina Healthcare will coordinate authorization requirements, benefits and services between the two products.

Admission Review

How do we request authorization for an urgent/emergent admission?

- Providers should call 855-322-4077
- Hospitals can call the UM Department or fax to 800-594-7404 during normal business hours
- For all urgent/emergent admissions, the hospital is required to provide clinical information once the determination is made to admit the member. Molina Healthcare ensures availability 24 hours per day, 7 days a week, by providing an On-Call Case Manager during non-business hours. If Molina Healthcare fails to respond within one (1) hour, the admission will be automatically approved.

What type of clinical information should be provided?

Clinical information should include the member's health history, vital signs, physical assessment, consultations, current and previous treatment including those services performed in the emergency department (ED) and outpatient settings and the member's response to treatment. Please include any anticipated discharge needs.

How does Molina Healthcare perform clinical review of urgent/emergent inpatient admissions?

If the admission does not meet InterQual® medical necessity criteria as an inpatient setting, the facility may admit the member to an observation setting, no authorization required. If the facility does not accept observation setting, the UM staff may request additional information and will forward the case for Medical Director review.

Requests for admission that meet InterQual® Inpatient Criteria, but could be treated in an observation setting (such as, rule out Myocardial Infarction/Chest Pain, Asthma, Congestive Heart Failure) and there is a likelihood of discharge within 24 hours in observation stay will be authorized initially for the following diagnoses:

- Acute Abdomen
- Acute Coronary Syndrome
- Acute Bronchitis
- Anemia
- Asthma
- Bronchiolitis
- Cellulitis or Abscess
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Deep Vein Thrombosis (DVT)
- Dehydration

Utilization Management Program

- Diabetes
- Disorders of Fluid, Electrolyte, and Acid-base Balance (Nausea, Vomiting)
- Gastroenteritis/Esophagitis
- General Symptoms
- Pneumonia, Organism Unspecified or Simple
- Poisoning/Toxic Ingestions
- Seizures
- Syncope or Decreased Responsiveness
- Unstable Angina

When would we contact you?

- If additional clinical information is required.
- If the need for additional medical services is identified post discharge, such as home health care or home infusion.
- To notify you of our decisions:
 - When services are approved, we will call you with an authorization number and next review date
 - When services are not approved, we will call you. Written notification is also sent at the time of the decision giving you the reason for the denial. Member and provider appeal rights are included with the notification. If you would like a copy of the criteria that was used to make a denial determination, or we would like to discuss a denial decision with a Medical Director, please call 855-322-4077.
 - For urgent/emergent admissions, we will call you within 72 hours of the receipt of the request.
 - If we are notified retrospectively of an admission and discharge, notification of our decision will be given within 14 days of the receipt of the request.

Concurrent Review/Discharge Planning/Continuity and Coordination of Care/Post Hospital Discharge/ Managing Care Transition

Why concurrent review/discharge planning/continuity and coordination of care?

Concurrent Review

Performed to determine medical necessity and appropriateness of a continued inpatient stay, to identify appropriate **discharge planning needs**, facilitate discharge to an appropriate setting in a timely manner and ensure **continuity and coordination** of the member's care. Our staff collaborates with the physician, hospital discharge planning, practitioners and their representatives.

Concurrent reviews are conducted once or twice a week as appropriate and InterQual® is used as a guideline in performing review.

How does the process work prior to discharge?

Utilization Management Program

Hospital discharge planning staff is responsible for ensuring authorization is obtained by calling 855-322-4077. The following select post discharge services require authorization:

- Home health care (including hospice, IV therapy, PT, OT, etc.)
- Infusion therapy
- Select durable medical equipment (DME)
- Skilled nursing facility (SNF)
- Rehabilitative services
- Hospice

Prior to or upon discharge from an inpatient facility, the hospital is responsible for providing the following information by calling 855-322-4077 or faxing to 800-594-7404:

- Discharge date
- Discharge plan (medications, appointments, ancillary service needs, etc.)
- Place of discharge
- Member phone number
- Alternative phone number and contact

How does the process work post hospital discharge?

Molina Healthcare UM staff (RN) will contact the member post discharge to evaluate if prescriptions were filled and the member is taking accurately, if post discharge appointments are scheduled, and if the member is following the discharge plan. If it is determined the member requires additional services that were not ordered at discharge, the UM staff will contact the member's PCP and/or attending physician to discuss the member's needs. The UM staff will arrange home care services or equipment as necessary.

In summary the program provides:

- Three phone attempts over two (2) week period following discharge.
- Letters to members and their PCPs
- Nursing assessment work
- Assistance with follow-up appointments
- Medication compliance monitoring
- Evaluation of compliance with discharge instructions
- Evaluation of current clinical condition
- Education on disease process

Medical Case Management

Who are we?

Our Complex Case Managers (CM) are RNs with specialized training in the management of specific diseases. We also have a clinical social worker on our team to provide psychosocial support to members.

Utilization Management Program

What services do the CMs provide?

Their role is to improve the health and well-being of each member by educating, assisting and facilitating access to the most appropriate health care services available. The CM has the responsibility to coordinate medical services throughout the member's continuum of care, while effectively reducing costs. The CMs assist:

- Identifying members who will benefit the most from case management services
 - Accept referrals from all Molina Healthcare areas and from physicians, hospital staff, etc.
- Developing a plan of care including problem identification, goals (including discharge from the program) and plan of care.
- Implementing interventions and service coordination within the benefit structure.
- Ensuring all services are medically necessary and provided at the appropriate level of care and in a timely manner.
- Coordinating such services as home health and hospice care, home infusion therapy, inpatient rehabilitation and skilled nursing care.
- Monitoring progress towards our goals.
- Reassessment and close the member to case management when appropriate.

The CMs are available to physicians, utilization review staff, discharge planners, the patient and patient's family to answer questions, attend care conferences and assist in facilitating a discharge plan or coordinating care.

Who is eligible for case management?

All Molina Healthcare members *are* eligible for case management and some members may be eligible for select case management programs. Members that may be referred for case management include those with:

- A known chronic disease
- Risk for developing chronic disease
- Multidisciplinary needs requiring case management intervention support
- Multiple hospital admissions with one more of the following conditions:
 - Cardiovascular Disease
 - Congestive Heart Failure
 - Chronic Obstructive Pulmonary Disease
 - End Stage Renal Disease
 - Asthma
 - Diabetes
 - Sickle Cell
 - AIDS/HIV
 - Cancer
 - High Risk Obstetric/Newborns

The following select case management programs are also available to support member's health care needs:

Utilization Management Program

- Asthma
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Coronary Artery Disease
- End Stage Renal Disease
- High Risk Obstetrics
- Pediatrics
- Skilled Nursing Facility and Rehabilitation
- Transplant/Oncology
- Social Work Services
- Frequent ED Use

If you would like to learn more information, speak with a CM and/or refer a member for an evaluation, please call our UM Department at 855-322-4077.

How to refer a member for case management?

Call the UM Department at 855-322-4077 during normal business hours.

How will you know if the member is accepted into case management?

You will receive a letter from a CM with their direct phone number.

When will you hear from us?

Our CMs perform an individualized member assessment. Following the assessment, the CM will send a letter informing you of the member's acceptance into the Case Management Program. The CM may periodically contact you regarding the member's progress.

Our CMs may contact you for other reasons:

- Coordinate a plan of care
- Confirm a diagnosis
- Verify appropriate follow up
- Identify member compliance issues
- Discuss other problems and issues that may affect the member's care

Utilization Management Program

On Call Program (After Hours)

Who are we and how should you contact us?

Molina Healthcare requests inpatient facilities to contact Molina Healthcare once a determination is made to admit a member from the ED but prior to the admission. By using the On-Call Program (After Hours) service the facility can obtain authorization prior to the admission. This service can also be used for discharge planning for hospitalized members.

What do we do?

We provide clinical staff availability 24 hours per day, 7 days per week to members, providers, and hospital, including after normal business hours, Monday-Friday (5:00 pm – 8:30 am), Saturday – Sunday and holidays.

The On-Call Case Manager contacts the facility to obtain clinical criteria (signs and symptoms, vital signs, lab results, diagnostic test results, medications with response, past medical history, plan of care) and applies InterQual® Medical Appropriateness Guidelines.

The On-Call Case Manager will facilitate one of the following:

- Approve inpatient admission in which an authorization number is provided along with the next review date.
- Observation services
- Pend for additional clinical information, in which the facility has 48 hours in which to supply Molina Healthcare with the requested information
- Discharge to home
- Discharge to home with home care, home infusion, and/or DME

When will you hear from us?

The On-Call Case Manager will contact the facility within one (1) hour maximum.

How can you reach us?

You can reach the On-Call Case Manager by calling 855-322-4077.

PROVIDER APPEALS

The UM Appeals/Denials area coordinates the provider appeals and Molina Healthcare Medical Directors review all appeals of denied decisions. All providers have the right to appeal any denial decision made by Molina Healthcare. Our appeal process is objective, thorough, fair and timely. A Molina Healthcare Medical Director may determine that a same specialty physician review may be needed. There are two types of provider appeals, administrative decisions and medical review.

Utilization Management Program

Administrative Denials

Molina Healthcare has a one (1) level appeal process for the practitioner appeal of post-service administrative denials. **Examples of administrative denials** are failure to authorize services according to required timeframes.

Level 1

- A. A practitioner must submit a written appeal within 90 days of the denial notification to:

Molina Healthcare of Michigan
Utilization Management Appeals
100 West Big Beaver, Suite 600
Troy, MI 48084

- B. The appeal must include new supporting evidence and/or documentation justifying the service, care or treatment being appealed, and reason for notification outside of Molina Healthcare notification timeframes. Portions of the medical record may be submitted.
- C. Upon receipt of the appeal, the Medical Director, or other qualified physician, will review all documentation submitted and fully investigate all aspects of the clinical care provided without deference to the original determination.
- D. The Medical Director, or other qualified physician, will/may consult with a physician of the same or similar specialty as the case in review.
- E. A decision will be rendered and written notification provided within 30 calendar days of the receipt of a post-service appeal.

Expedited Appeal: Molina Healthcare will expedite an appeal and render a decision within 72 hours of the request if a longer timeframe could seriously jeopardize the life or health of the member or would subject the member to severe pain that cannot be adequately managed without the care that is subject of the request.

Rights to copies of documents: A practitioner may request Molina Healthcare to furnish all documents relevant to the member's appeal as well as copies of the actual benefit provision, guideline, protocol or criteria on which the appeal decision was based.

Right to know practitioners participating in the appeal: A practitioner may request Molina Healthcare to furnish the names, titles and qualifications of any medical experts whose advice was obtained on behalf of Molina Healthcare in connection with the appeal, without regard to whether the advice was relied upon in making the appeal decision.

Medical Necessity Denials

Molina Healthcare of Michigan has a two (2) level appeal process for the practitioner appeal of post-service medical necessity denials. **Examples of medical necessity denials** are inpatient admission which did not meet InterQual® criteria, or a request which did not meet medical criteria guidelines.

Level 1

Utilization Management Program

- A. A practitioner must submit a written appeal within 90 days of the denial notification to:

Molina Healthcare of Michigan
Utilization Management Appeals
100 West Big Beaver, Suite 600
Troy, MI 48084

- B. The appeal must include new supporting evidence and/or documentation justifying the service, care or treatment being appealed. Portions of the medical record may be submitted.
- C. Upon receipt of the appeal, the Medical Director, or other qualified physician, will review all documentation submitted and fully investigate all aspects of the clinical care provided without deference to the original determination.
- D. The Medical Director, or other qualified physician, will/may consult with a physician of the same or similar specialty as the case in review.
- E. A decision will be rendered and written notification provided within 30 calendar days of the receipt of a post-service appeal.

Level 2

- A. If you disagree with the decision at Level 1, a practitioner must submit a second written appeal within 90 days of the date of the Level 1 denial notice to the same address as listed in Level 1. The request must clearly state it is for a Level 2 review.
- B. The written request must include additional supporting documentation justifying the need for the denied service.
- C. The appeal will/may be reviewed by a Medical Director or by a consultant of same or similar specialty.
- D. The Medical Director will render a decision and written notification will be provided within 30 calendar days of the receipt of a post-service appeal.

Expedited Appeal: Molina Healthcare of Michigan will expedite an appeal and render a decision within 72 hours of the request if a longer timeframe could seriously jeopardize the life or health of the member or would subject the member to severe pain that cannot be adequately managed without the care that is subject of the request.

Rights to copies of documents: A practitioner may request Molina Healthcare of Michigan to furnish all documents relevant to the member's appeal as well as copies of the actual benefit provision, guideline, protocol or criteria on which the appeal decision was based.

Right to know practitioners participating in the appeal: A practitioner may request Molina Healthcare to furnish the names, titles and qualifications of any medical experts whose advice was obtained on behalf of Molina Healthcare in connection with the appeal, without regard to whether the advice was relied upon in making the appeal decision.

The Claim Dispute/Appeal Form should be used for the appeal type listed below:

Claim Dispute/Appeal Form can be found on the website
at <http://www.molinahealthcare.com/medicaid/providers/mi/forms/Pages/fuf.aspx>

Utilization Management Program

Timely Filing Appeals

Providers may submit an appeal for timely filing and/or coding edit (CCI edit denials) by following the steps below:

- Timely Filing appeals must be submitted with supporting documentation showing claim was filed in a timely manner.
- Complete a Claims Dispute/Appeal Request Form, or submit an appeal letter with supporting documentation.
- **Mail your Timely Filing appeal to:**

Molina Healthcare
Attention: Claims Department
100 W. Big Beaver Road, Suite 600
Troy, MI 48084-5209

- **Or fax to : 248- 925- 1768 Attention Timely Filing appeal**

Code Edit Appeals (CCI Edits)

- CCI Edit appeals must be submitted with supporting documentation and medical notes/reports.
- Only submit non-corrected claims as appeals
- Complete a Claims Dispute/Appeal Request Form, or submit an appeal letter with supporting documentation.
- **Mail your CCI Edit appeal to:**

Molina Healthcare
Attention: Claims Department
100 W. Big Beaver Road, Suite 600
Troy, MI 48084-5209

- **Or fax to : 248- 925- 1768 Attention CCI Edit appeal**

Rapid Dispute Resolution

Plan supports the Michigan Department of Community Health (MDCH) Rapid Dispute Resolution Process (RDRP) for hospitals under the MDCH Access Agreement. The purpose of this policy and procedure is to ensure Provider disputes are processed in a timely and efficient manner with adherence to State/Federal Regulations. Provider disputes will be reviewed to determine the appropriate resolution.

Utilization Management Program

Request for Binding Arbitration

A request for arbitration may be submitted in writing to MHM's Provider Inquiry Research and Resolution department after all MHM appeal processes have been exhausted. Arbitration must be initiated within one year of the earlier of the date the claim or controversy arose, was discovered or should have been discovered with reasonable diligence; otherwise it shall be deemed waived. MHM's Legal department will coordinate the binding arbitration process in accordance with the American Arbitration Association rules for Arbitration for Non Contracted providers, and pursuant to the provisions of the Provider Agreement for Contracted providers. Arbitration disputes will be processed in a timely and efficient manner with adherence to State/Federal Regulations.

Send All Written Requests for Arbitration to:

Molina Healthcare of Michigan
Attention: Provider Inquiry Research and Resolution (Arbitration)
100 W. Big Beaver Rd. Suite 600
Troy, Michigan, 48084-5209