Types of Medicaid Notifications

MOLINA HEALTHCARE

Molina Healthcare of Texas

Some services need a preauthorization process. This process shows if the service is a covered benefit and if that benefit is "medically necessary." This means a provider works with Molina to decide that a health care service is clinically appropriate or clinically significant, in terms of type, frequency, event or site, according to any applicable, generally accepted principles and practices of good medical care or practice guidelines. The table below shows the different types of notices a provider and/or member may get during the preauthorization process. Molina follows the Uniform Managed Care Manual (UMCM) for all notification requirements.

Member and/or Provider Notification	Type of Notice	Definition
Member and Provider	Standard Extension Notice	Extension to the preauthorization process is when more time is needed to complete the request for service review. Reasons for an extension: • You or your physician asked for an extension so that more information could be gathered. • Or Molina feels that we may be able to approve the request with more information. Appeal rights are available if the member disagrees.
Provider and/or Member	Notification for Incomplete Prior Authorization Requests	If Essential Information on a PA request is missing, incorrect, or illegible, Molina will not enter the request into the system. Molina will reject the request to the provider with an explanation of why the submitted request was not processed as submitted and include instruction to resubmit the PA request with complete Essential Information. If a PA request is missing documentation to determine medical necessity and it will likely result in an Adverse Benefit Determination, the PA request must be limited to the PA requirements listed on Molina's website on the date the request is received. Molina will utilize the PA request process described in this chapter to request additional documentation. Molina will issue coverage determinations for Incomplete PA Requests according to the following timelines: • Notify the requesting provider and Member, in writing, of missing information no later than 3 Business Days after the PA Receive Date. Additionally, Molina is permitted to contact the provider by telephone and obtain the information necessary to resolve the Incomplete PA Request. Molina's written request for additional information must include the following: o A statement that Molina has reviewed the

		PA request and is unable to make a decision about the requested services without the submission of additional information. o A clear and specific list and description of missing/incomplete/incorrect information or documentation that must be submitted in order to consider the request complete. o An applicable timeline for the provider to submit the missing information. o Information on the manner through which a provider may contact Molina.
Member and Provider	Inpatient Standard Extension Letter	Response to inpatient admission where the facility did not submit enough information in order to make a decision. Or requests for an extension can also happen because: • You or your physician asked for an extension, • Or we need more information, and it is in your best interest to extend the request to get that information. Molina will wait to review the admission until additional information is submitted but will make a determination within 14 days of receiving the request. Appeal rights are available if the member disagrees.
Provider	Peer to Peer Notice	Before sending an adverse benefit determination, Molina allows one business day or a reasonable opportunity to the requesting provider to discuss the medical necessity of the service being requested.
Member	Approval Letter	Approval letter is mailed to the member to inform when services are approved.
Provider	Approval Notification	Providers receive faxed approval notifications of pre-authorized services to include type and quantity. All approved authorizations will have this standard disclaimer as well: **Disclaimer:** This authorization number is not a guarantee of reimbursement/payment. Reimbursement is based on eligibility, medical necessity, and the benefit provisions of the patient's plan at the time services are rendered. If services, Providers, or dates of service change from the dates indicated, Molina Healthcare must be notified prior to services being rendered or it could result in nonpayment of an associated claim
Member and Provider	Children and Pregnant Women (CPW) Service Coordination Available Services	Faxed to the provider and mailed to the member when services requested by a CPW case manager can be provided by a Molina Service Coordinator.
Member and Provider	CHIP Administrative Denial Letter	When a service is not approved due to non-covered benefit, Molina will send an administrative denial letter which includes, but not limited to: 1. The dates, types and amount of service requested. 2. The type of action Molina has taken or plans to take (such as non-covered request, non-participating

		provider, etc.). 3. The date Molina will take the action. 4. An explanation of the reasons for the Molina's decision. 5. How to contact Molina if another language is needed 6. A description of Molina's complaint process
Member and Provider	CHIP Adverse Determination Letter	When a service is not approved, Molina will send a formal adverse benefit determination letter which includes, but not limited to: 1. The dates, types and amount of service requested. 2. The type of action Molina has taken or plans to take (such as denial or limited authorization of a requested service; reduction, suspension, or termination of a previously authorized service, etc.). 3. The date Molina will take the action. 4. An explanation of the reasons for the Molina's decision. 5. How to contact Molina if another language is needed 6. A description of Molina's internal appeals process 7. Details of the State Fair Hearing/Independent Review Organization process
Member and Provider	Adverse Benefit Determination Letter	Molina follows the Letter Templates required per the Uniform Managed Care Manual; Chapter 3.21; MMC Service Authorization Notice Requirements. https://www.hhs.texas.gov/sites/default/files/documents/3-21.pdf When a service is not approved, Molina will send a formal adverse benefit determination letter which includes, but not limited to: 1. The dates, types and amount of service requested. 2. The type of action Molina has taken or plans to take (such as denial or limited authorization of a requested service; reduction, suspension, or termination of a previously authorized service, etc.). 3. The date Molina will take the action. 4. An explanation of the reasons for the Molina's decision. 5. How to contact Molina if another language is needed 6. A description of Molina's internal appeals process 7. Details of the State Fair Hearing process 8. Where to get help getting low-cost legal services