Provider Bulletin

Molina Healthcare of Texas, Inc.

June 10, 2025

News from Molina Healthcare of Texas, Inc.

Molina Healthcare has launched our new Claim Reconsideration function in the Availity Portal!
(All Lines of Business)

What is a reconsideration?
A reconsideration is the review of a claim that a provider believes was paid or denied incorrectly due to potential Molina error. It is different from a claims appeal. Providers should submit a reconsideration when a minor error is suspected and can be easily identified. Claims requiring a medical necessity review, correct coding review, or claims requiring attachments (e.g., medical records) should be submitted as a claim appeal in Availity. Examples of reconsideration requests include:

- Claim or claim line(s) denied for no authorization however there is an approved authorization for the service.
- Claim denied for Out of Network when the provider is In Network.
- Claim denied for the member not being eligible on the DOS, but the member shows as eligible.
- Claim denied for primary EOB, but the member does not have other health insurance listed with Molina Healthcare for the DOS.

Key Features:

- **Average Turnaround Time for:**
  - Less complex issues**,** fifteen (15) business days.
  - More complex issues, forty-five (45) to sixty (60) days.
- **Resolution Process**:
  - Regardless of complexity you will receive a response to your reconsideration through Availity.
  - If it is appropriate to reprocess the claim, you will receive a new explanation of payment.
- **Communication**: All communication regarding your reconsideration will occur via messages in the Availity portal.
- **Attachments:** If your issue requires supporting documentation DO NOT submit a reconsideration. You must submit an appeal.
- **Corrected Claims:** If you have identified a billing error, please submit a corrected claim not a reconsideration or an appeal.

What types of claim issues are not appropriate to send as a reconsideration?

- Denials for code edits should be submitted as an appeal.
- Claims denied due to the authorization being denied.
- The services billed are considered not covered or non-covered in the applicable state fee schedule.
- Claims denied for the services billed exceeding the authorization.
- Untimely Filing – claims that are not filed/submitted to Molina within the time limit for initial/corrected claim submission.
- **Behavioral Health, Tribal Health, or Health Home claims denied or incorrectly paid should be filed as an appeal to ensure the appropriate team addresses your issue.**

Providers can log on or register for Availity here at https://www.availity.com/molinahealthcare/