PROVIDER MANUAL

Molina Healthcare of Illinois, Inc.

(Molina Healthcare or Molina)

Medicaid Program

2021

The Provider Manual is customarily updated annually but may be updated more frequently as policies or regulatory requirements change. Providers can access the most current Provider Manual at MolinaHealthcare.com.

Last Updated 11/2021

Welcome to Molina Healthcare of Illinois

Molina Healthcare (Molina) would like to thank you for participating in the care of our Members. Our Provider Manual was designed to assist you with understanding plan policies, procedures, and other protocols.

The current Provider Manual is available 24/7 in the Provider section of the Molina website, under the Manual tab. Contact your Provider Network Manager or the Provider Network Management team with any questions or concerns at **(855) 866-5462** or MHILProviderNetworkManagement@MolinaHealthcare.com.

In addition to the Provider Manual, Molina issues many important updates throughout the year. These updates and critical notifications are posted on the Provider website under the Communications tab; select News & Updates.

To receive these important notifications automatically, we recommend that you register for our Provider emails.

The quality care of our Members is our ultimate goal. Thank you for being part of the Molina family.

Molina Healthcare of Illinois Team

New and Different for 2021

The following lists some of the most noteworthy additions and updates to this Molina Medicaid Provider Manual. It does **not** list all changes. Providers should review and become familiar with the entire document.

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1. Introduction

Medicaid Plan
In Illinois, Molina offers two Medicaid health programs, as well as a Medicare-Medicaid Plan.

HealthChoice Illinois
The Molina HealthChoice Illinois health plan offers free medical coverage to seniors and people with disabilities, children, pregnant women, families, and adults who qualify for Illinois Medicaid. The program was previously known as Family Health Plan and Integrated Care Program.

Health Choice Illinois MLTSS
The HealthChoice Illinois Managed Long-Term Support and Services (MLTSS) plan provides waiver and other services to individuals who qualify for both Medicare and Medicaid, but who are not part of the Medicare-Medicaid Alignment Initiative (MMAI).

2. Addresses and Phone Numbers

Molina Healthcare of Illinois, Inc.
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523

Provider Network Management Department
The Provider Network Management department handles telephone and written inquiries from Providers regarding address and Tax-ID changes, Provider denied claims review, contracting, and training. The department has Provider Network Managers who serve all of Molina's Provider Network.

Provider Email	Phone
MHILProviderNetworkManagement@MolinaHealthcare.com	(855) 866-5462

Member Services Department
The Member Services department handles all telephone and written inquiries regarding Member claims, benefits, eligibility/identification, selecting or changing Primary Care Providers (PCPs), and Member complaints. Member Services Representatives are available seven (7) days a week, from 8 a.m. to 5 p.m. Central Time, excluding holidays. Eligibility verifications can be conducted at your convenience via the Provider Portal.

Phone	Hearing Impaired (TTY/TDD)
(855) 687-7861 (English & Spanish)	711

Claims Department
Molina requires Participating Providers to submit claims electronically (via a clearinghouse or the Provider Portal).

- Access the Provider Portal
- EDI Payer ID number 20934

To verify the status of your claims, please use the Provider Portal. For other claims questions, contact Provider Network Management.

Portal	Phone
provider.MolinaHealthcare.com	(855) 866-5462

Claims Recovery Department
The Claims Recovery department manages recovery for overpayment and incorrect payment of claims.

Address	Fax
Molina Healthcare of Illinois, Inc. Bin 88826 Milwaukee, WI 53288-0826	(855) 260-8740

Compliance/Anti-Fraud Hotline

If you suspect cases of fraud, waste, or abuse, you must report it to Molina. You may do so by contacting the Molina AlertLine or submitting an electronic complaint using the website listed below. For more information about fraud, waste, and abuse, please see the Compliance section of this Provider Manual.

Phone	Website	Address
(866) 606-3889	MolinaHealthcare.alertline.com	Confidential Compliance Official Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802

24-Hour Nurse Advice Line

This telephone-based nurse advice line is available to all Molina Members. Members may call any time they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, seven (7) days a week to assess symptoms and help make good health care decisions.

Nurse Advice Line (HEALTHLINE) 24 hours per day, 365 days per year	
English Phone - (888) 275-8750	**English TTY** – (888) 735-2929
Spanish Phone - (866) 648-3537	**Spanish TTY** – (866) 833-4703

Health Care Services Department

The Health Care Services (formerly UM) department conducts concurrent review on inpatient cases and processes Prior Authorizations/Service Requests. The Health Care Services (HCS) department also performs Care Management for Members who will benefit from such services. Participating Providers are required to interact with Molina's HCS department electronically whenever possible. Prior Authorizations/Service Requests and status checks can be easily managed electronically.

Managing Prior Authorizations/Service Requests electronically provides many benefits to Providers, such as:

- Easy to access to 24/7 online submission and status checks.
- Ensures HIPAA compliance.
- Ability to receive real-time authorization status.
- Ability to upload medical records.
- Increased efficiencies through reduced telephonic interactions.
- Reduces cost associated with fax and telephonic interactions.

Molina offers the following electronic Prior Authorizations/Service Requests options:

- Submit requests directly to Molina Healthcare of Illinois via the Provider Portal. See the Provider Portal Quick Reference Guide or contact your Provider Network Manager for registration and submission guidance.
- Submit requests via 278 transactions. See the EDI transaction section of Molina's website for guidance.

Portal	Phone
provider.MolinaHealthcare.com	(866) 409-2935

Health Management Level 1 and Health Management Department
Molina's Health Management Level 1 (previously Health Education) and Health Management (previously Disease Management) Programs will be incorporated into the Member's treatment plan to address the Member's health care needs.

Phone	TTY/TDD
Member Services (855) 687-7861 (English & Spanish)	711

Behavioral Health
Molina manages all components of covered services for Behavioral Health. For Member Behavioral Health needs, please contact Molina directly.

Phone	TTY/TDD
Member Services (855) 687-7861 (English & Spanish)	711

Pharmacy Department
For pharmacy services, contact:

Phone	TTY/TDD
(855) 866-5462	711

Quality Improvement
Molina maintains a Quality Improvement (QI) department to work with Members and Providers in administering the Molina Quality Improvement Program.

Phone	Fax
(855) 866-5462	(855) 556-2074

Supplemental Services
Molina offers the following supplemental services benefits.

Service	Vendor Name & Address	Telephone
Dental	Avēsis	(800) 327-4462
Vision	Avēsis	Medicaid (866) 857-8124 MMP/Duals (855) 704-0433
Transportation	MTM Inc. (non-emergency transportation)	HealthChoice Illinois: (844) 644-6354 MMP: (844) 644-6353 Schedule rides for Members: (855) 740-3105

3. Benefits and Covered Services

This section provides an overview of the medical benefits and Covered Services for Molina Healthcare of Illinois Members. Some benefits may have limitations. If there are questions as to whether a service is covered or requires Prior Authorization please contact Molina at **(855) 866-5462**, available 8 a.m. to 5 p.m., Central Time Monday through Friday, excluding state and federal holidays.

HealthChoice Illinois Benefits and Covered Services
Service Covered by Molina
Molina covers the services described in the Summary of Benefits documentation. If there are questions as to whether a service is covered or requires prior authorization, please contact Molina at **(855) 866-5462** available 8 a.m. to 5 p.m. Central Time Monday through Friday, excluding state and federal holidays.

Link to Summary of Benefits
The following link provides access to the Summary of Benefits guides for HealthChoice Illinois offered by Molina in Illinois, molinahealthcare.com/members/il/en-US/PDF/Medicaid/member-handbook-healthchoice-illinois.pdf

Obtaining Access to Certain Covered Services
Non-Preferred Drug Exception Request Process
The Provider may request a prior authorization for clinically appropriate drugs that are not covered under the Member's Medicaid Plan. Using the FDA label, community standards, and high levels of published clinical evidence, clinical criteria are applied to requests for medications requiring prior authorization.

- For a Standard Exception Request, the Member and/or Member's Representative and the prescribing Provider will be notified of Molina's decision within 24 hours of receiving the complete request.
- If the initial request is denied, a notice of denial will be sent in writing to the Member and prescriber within 24 hours of receiving the complete request.
- Members will also have the right to appeal a denial decision, per any requirements set forth by Department of Healthcare and Family Services (HFS).
- Molina will allow a 72-hour emergency supply of prescribed medication for dispensing at any time that a prior authorization is not available. Pharmacists will use their professional judgment regarding whether there is an immediate need every time the 72-hour option is utilized. This procedure will not be allowed for routine and continuous overrides.

Specialty Drug Services
Many self-administered and office-administered injectable products require Prior Authorization (PA). In some cases, they will be made available through a vendor, designated by Molina. More information about our prior authorization process, including a link to the Prior Authorization Request Form, is available in the Health Care Services section of this Manual. Physician administered drugs require the appropriate 11-digit NDC with the exception of vaccinations or other drugs as specified by CMS.

Injectable and Infusion Services
Many self-administered and office-administered injectable products require Prior Authorization (PA). In some cases, they will be made available through a vendor designated by Molina. More information about our Prior Authorization process, including a link to the PA request form, is available in the Pharmacy section of this Provider Manual.

Family planning services related to the injection or insertion of a contraceptive drug or device are covered at no cost.

Access to Behavioral Health Services
Members in need of Behavioral Services can be referred by their PCP for services or Members can self-refer by calling the number on their Molina Healthcare ID card. Also, Molina's Nurse Advice Line is available 24 hours a day, seven days a week (24/7) for mental health or substance abuse needs. The services Members receive will be confidential. Additional detail regarding Covered Services and any limitations can be obtained in the Summary of Benefits link above, or by contacting Molina.

Emergency Mental Health or Substance Abuse Services
Members are directed to **call 911** or go to the nearest Emergency Room if they need Emergency Services for mental health or substance abuse. Examples of emergency mental health or substance abuse problems are:

- Danger to self or others.
- Not being able to carry out daily activities.
- Things that will likely cause death or serious bodily harm.

Out of Area Emergencies
Members having a behavioral health emergency who cannot get to a Molina-approved Provider are directed to do the following:

- Go to the nearest Emergency Room.
- Call the number on ID card.
- Call Member's PCP and follow-up within 24 to 48 hours.

For out-of-area Emergency Services, plans will be made to transfer Members to an in-network facility when Member is stable.

Emergency Transportation
When a Member's condition is life-threatening and requires use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility, emergency transportation is thus required. Emergency transportation includes, but is not limited to, ambulance, air, or boat transports.

Non-Emergency Medical Transportation

Non-emergency medical transportation is an available benefit to all Members. Requests for transportation should be made through our transportation vendor three (3) days in advance of the scheduled appointment, at which time a reference number will be provided. A reference number is **required** for claims to be considered eligible for reimbursement. Examples of non-emergent transportation include, service cars, medicars (such as wheelchair-accessible vans, paralift, and stretcher vans), and taxicabs, along with personal gas mileage reimbursement for Members who drive themselves. For Members who are ambulatory with non-limiting physical conditions, bus tickets for mass transit are also available.

For non-emergent rides that require an ambulance level of transport, such as ALS/BLS, claims should be submitted directly to Molina for adjudication, and do **not** require Prior Authorization. If an ambulance ride met the requirements of a medicar or service car, the claim should be submitted to the vendor. In addition, if the ambulance ride was requested directly from a hospital or medical facility and the level of service was **not** ALS/BLS, the ambulance Provider will be required to submit a post-authorization request from the vendor within 20 days of transport.

For facilities requesting transportation due to discharge, three-day notice is **not** required. Providers can call the dedicated facilities phone number (855) 740-3105.

Children are not permitted to be transported alone under the age of 16 unless it is for intensive Behavioral Health outpatient day treatment, family planning services, or pregnancy services. Additional information regarding the availability of this benefit is available by contacting Provider Network Management at **(855) 866-5462**.

Preventive Care

Preventive Care Guidelines are located on the Molina website. Please use this link to access the most current guidelines:
molinahealthcare.com/providers/il/medicaid/resource/Pages/prevent.aspx.

We need your help conducting these regular exams in order to meet the targeted state and federal standards. If you have questions or suggestions related to well child care, please call our Health Education line at **(855) 866-5462**.

Immunizations

Adult Members may receive immunizations as recommended by the Centers for Disease Control and Prevention (CDC) and prescribed by the Member's PCP. Child Members may receive immunizations in accordance with the recommendations of the American Academy of Pediatrics (AAP) and prescribed by the child's PCP.

Immunization schedule recommendations from the American Academy of Pediatrics and/or the CDC are available at the CDC website:
cdc.gov/vaccines/schedules/hcp/index.html.

Molina covers immunizations not covered through Vaccines for Children (VFC).

Well Child Visits and EPSDT Guidelines

The Federal Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit requires the provision of early and periodic screening services and well care examinations to individuals from birth until 21 years of age, with diagnosis and treatment of any health or mental health problems identified during these exams. The standards and recurrent schedule generally follow the recommendations from the AAP and Bright Futures.

Molina Providers are eligible for additional reimbursement for the services listed below when billed with appropriate CPT codes as listed in the HFS Healthy Kids Handbook, which can be found online at illinois.gov/hfs/SiteCollectionDocuments/hk200.pdf.

The screening services include:

- Comprehensive health and developmental history (including assessment of both physical and mental health development).
- Immunizations in accordance with the most current American Academy of Pediatrics, Centers for Disease Control and Prevention Advisory Committee on Immunization Practices Childhood Immunization Schedule, as appropriate.
- Comprehensive unclothed physical exam.
- Laboratory tests as specified by the AAP, including screening for lead poisoning.
- Health education.
- Vision services.
- Hearing services.
- Dental services.

When a screening examination indicates the need for further evaluation, Providers must provide diagnostic services or refer Members, when appropriate, without delay. Providers must provide treatment or other measures (or refer when appropriate) to correct or improve defects and physical and mental illness or conditions discovered by the screening services.

We need your help conducting these regular exams in order to meet Molina's targeted state standard. Providers must use correct coding guidelines to ensure accurate reporting for EPSDT services. If you have questions or suggestions related to EPSDT or well child care, please call our Health Education line at **(855) 866-5462**.

Prenatal Care

Stage of Pregnancy	How often to see the doctor
One (1) month to six (6) months	One (1) visit a month
Seven (7) months to eight (8) months	Two (2) visits a month
Nine (9) months +	One (1) visit a week

Emergency Services

Emergency Services means inpatient and outpatient health care services that are Covered Services (including transportation) needed to evaluate or stabilize an emergency medical condition, and which are furnished by a Provider qualified to furnish Emergency

Services. Emergent and urgent care services are covered by Molina without an authorization. This includes non-contracted Providers inside or outside of Molina's service area.

Nurse Advice Line
Members may call the Nurse Advice Line any time they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, seven days a week, to assess symptoms and help Members make good health care decisions.

Nurse Advice Line (HEALTHLINE) 24 hours per day, 365 days per year	
English Phone - (888) 275-8750	**English TTY** – (888) 735-2929
Spanish Phone - (866) 648-3537	**Spanish TTY** – (866) 833-4703

Molina is committed to helping our Members:
- Prudently use the services of your office.
- Understand how to handle routine health problems at home.
- Avoid making non-emergent visits to the Emergency Room (ER).

These registered nurses **do not** diagnose. They assess symptoms and guide the patient to the most appropriate level of care following specially designed algorithms unique to the Nurse Advice Line. The Nurse Advice Line may refer back to the PCP, a specialist, 911 or the ER. Educating patients reduces costs and overutilization of the health care system.

Children's Behavioral Health Services
Molina's Provider Network includes the necessary levels of care, with sufficient intensity, required to meet the needs of Members. These levels of care include alternatives to institutions, such as Psychiatric Residential Treatment Facilities (PRTFs) and hospitals, when clinically appropriate.

Mobile Crisis Response Services
Molina coordinates with pediatric mental health crisis intervention services available through the Illinois Mobile Crisis Response (MCR) Program when a Member in crisis can be stabilized in the community. MCR intervention services are a covered benefit for Members who are younger than 21 years of age.

Molina's mobile crisis response services are modeled after the state program, formerly known as the Screening, Assessment, and Support Systems (SASS) Program. Molina's model of care for mobile crisis response includes referrals from the CARES Line, **(800)-345-9049**, and use of the Illinois Medicaid-Crisis Assessment Tool (IM-CAT) tool.

When appropriate, the CARES line will dispatch Molina's contracted crisis responder to the Member's location. The first responder then completes the IM-CAT to determine whether the Member can be stabilized in the community. Behavioral health Providers in the Molina network are required to send results of the IM-CAT and assessment tool to Molina within 24 hours of the completion of MCR screening for a Molina Member.

IM-CAT results can be submitted to Molina via secure email or fax.

Email: MHILbehavioralhealthreferrals@MolinaHealthcare.com
Fax: (866) 916-3249

CARES Case Managers
Members who are the subject of a CARES line call are assigned to a Molina Case Manager to help support their aftercare. These Case Managers can be a resource for the mobile crisis response team. Molina's partnership with the MCR Program will help Molina monitor prioritization of aftercare counseling and psychiatry for its Members.

Crisis Intervention Outside of the Mobile Crisis Response Service
If a Member seeks crisis intervention service outside of the Molina's MCR Service System and a crisis call is routed to CARES for a crisis referral, Molina will reimburse CARES at the annual CARES per call rate. Molina will accept invoices from CARES on a monthly basis and return payment to CARES within 45 days after receiving an invoice for crisis referral services.

Crisis Safety Plan
MCR Providers are responsible for creating a crisis safety plan in collaboration with the Member and the Member's family. The plan should be shared with all necessary medical professionals, including Care Coordinators, consistent with the authorizations established by consent or release.

Members will be provided with copies of the crisis safety plans:
- Prior to the completion of the crisis screening for any Member stabilized in the community.
- Prior to the Member's discharge from an inpatient psychiatric hospital setting.

Providers are responsible for:
- Educating the Member's family about the crisis safety plan.
- Ensuring that the plan is reviewed with the family regularly.
- Updating the plan, as necessary.

Health Management Programs
Health Management
The tools and services described here are educational support for Molina Members. We may change them at any time as necessary to meet the needs of Molina Members.

Health Education/Disease Management
Molina offers programs to help our Members and their families manage various health conditions. The programs include telephonic outreach from our clinical staff and health educators, along with access to educational materials. You can refer Members who may benefit from the additional education and support Molina offers. Members can request to be enrolled or disenrolled in these programs at any time. Our programs include:
- Asthma management.
- Diabetes management.

- High blood pressure management.
- Heart failure.
- Chronic Obstructive Pulmonary Disease (COPD) management.
- Depression management.
- Obesity.
- Weight management.
- Smoking cessation.
- Organ transplant.
- Serious and Persistent Mental Illness (SPMI) and Substance Use Disorder (SUD).
- Maternity screening and high-risk obstetrics.

For more information about our programs, please call Provider Network Management at **(855) 866-5462** (TTY/TDD at 711 Relay) or visit MolinaHealthcare.com. For additional information, please refer to the Healthcare Services section of this Provider Manual.

Telehealth and Telemedicine Services
Molina Members may obtain Covered Services by Participating Providers through the use of telehealth and telemedicine services. Not all Participating Providers offer these services. The following additional provisions apply to the use of telehealth and telemedicine services:

- Services must be obtained from a Participating Provider.
- Services are meant to be used when care is needed now for non-emergency medical issues.
- Services are a method of accessing Covered Services and not a separate benefit.
- Services are not permitted when the Member and Participating Provider are in the same physical location.
- Services do not include texting, facsimile, or email only.
- Services include preventive and/or other routine or consultative visits during a pandemic.
- Covered Services provided through store-and-forward technology must include an in-person office visit to determine diagnosis or treatment.

Upon at least ten (10) days prior notice to Provider, Molina shall further have the right to a demonstration and testing of Provider telehealth service platform and operations. This demonstration may be conducted either virtually or face-to-face, as appropriate for telehealth capabilities and according to the preference of Molina. Provider shall make its personnel reasonably available to answer questions from Molina regarding telehealth operations.

For additional information on telehealth and telemedicine claims and billing, please refer to the Claims and Compensation section of this Provider Manual.

4. Long-Term Services and Support (LTSS)

LTSS Overview
LTSS includes both Long-Term Care (LTC) and Home and Community-Based Services (HCBS).

- Long-Term Care Programs are when an individual is living in a facility-based care setting (such as a nursing home or intermediate care facility).
- Home and Community-Based Services Programs provide alternatives to living in facility-based care settings. These programs empower consumers to take an active role in their health care and to remain in the community. The programs serve older adults or people with disabilities.

Molina understands the importance of working with our Providers and Community Based Organizations (CBOs) in your area to ensure our Members receive LTSS services that maintain their independence and ability to remain in the community.

Molina's LTSS Provider Network is a critical component to ensuring our Members receive the right care, in the right place, at the right time. The following information has been included to help support our LTSS Provider Network and achieve a successful partnership in serving those in need.

LTSS Services and Molina Healthcare
Molina offers services to Members of the following waiver programs:

- Persons who are elderly.
- Persons with disabilities.
- Persons with HIV/AIDS.
- Persons with brain injury.
- Supportive living facility.

Services offered under these waivers are designed to assist Members maintain self-sufficiency, individuality, independence, dignity, choice, and privacy in their home or a cost-effective home-like setting. Services for eligible Members are provided in the Member's home or assisted living facility. These waiver programs provide eligible individuals the ability to choose and receive the care they need in the home or community rather than in an institution.

LTSS Benefits and Approved Services
Adult Day Service—Provides direct care and supervision of adults in a community-based setting for the purpose of providing personal attention and promoting social, physical, and emotional well-being in a structured setting.

Adult Day Health Transportation—Provides transportation from a Member's home to the adult day health facility. Does not include transportation to any other service or location.

Day Habilitation—Assists with the acquisition, retention, or improvement in self-help, socialization, and adaptive skills in a non-residential setting, separate from the home or

facility in which the Member resides. The focus is to enable the Member to attain or maintain his or her maximum functional level. Day habilitation shall be coordinated with any physical, occupational, or speech therapies. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

Environmental Accessibility Adaptations—Provides physical adaptations to the home required by the Member's Care Plan, which are necessary to ensure the health, welfare, and safety of the individual, or which enable the Member to function with greater independence in the home, and without which the Member would require institutionalization.

Home Delivered Meals—Prepared food brought to the Member's residence that may consist of a heated luncheon meal and/or a dinner meal that can be refrigerated and eaten later.

Homemaker—This service pays two (2) different prices: one for agencies that do not pay for employee insurance and one for agencies that do. The Provider information regarding which agency will pay employee insurance and which agency will not pay employee insurance will be on the waiver-approved Provider list that Molina Healthcare will receive from the state. Homemaker service is defined as general non-medical support by supervised and trained homemakers. Homemakers are trained to assist Members with their activities of daily living, including personal care, as well as other tasks such as laundry, shopping, and cleaning.

Personal Emergency Response System (PERS)—PERS is an electronic device that enables certain Members at high risk of institutionalization to secure help in an emergency. The Member may also wear a portable "help" button to allow for mobility. The system is connected to the Member's phone and programmed to signal a response center once the button is activated. PERS services are limited to those Members who live alone or who are alone for significant parts of the day and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

Respite—Respite services provide relief for unpaid family or primary care givers who are currently meeting all service needs of the Member. Services are limited to individual Provider, homemaker, nurse, adult day care, and provided to a Member to aid his or her activities of daily living during the periods of time it is necessary for the family or primary care giver to be absent.

Skilled Nursing Services RN/LPN—Service provided by an individual that meets Illinois licensure standards for nursing services and provides shift nursing services.

Specialized Medical Equipment and Supplies—Specialized medical equipment and supplies includes devices, items, and appliances that enable the Member to perform Activities of Daily Living (ADL). Limit: Items over $500 will require three competitive bids.

Supported Employment—Provides supported employment services that consist of intensive, ongoing supports that enable Members, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports to perform in a regular work setting. It may include assisting the Member to locate a job or develop a job on behalf of the Member and is conducted in a variety of settings, including work sites where persons without disabilities are employed.

Personal Care Services (Individual Provider)—A self-directed service reimbursed by HFS. Individual Providers provide assistance with eating, bathing, personal hygiene, and other Activities of Daily Living. This service may also include such housekeeping chores as bed making, dusting, and vacuuming, which are incidental to the care furnished or which are essential to the health and welfare of the consumer, rather than the Member's family. Personal care services are a covered benefit for the following waivers: people with disabilities, HIV/AIDS, and traumatic brain injury.

Home Health Aide—Provides services by an individual that meets Illinois licensure standards for a Certified Nursing Assistant. Services provided are in addition to any services provided through the state plan.

Nursing, Intermittent—Nursing services that are within the scope of the state's Nurse Practice Act and are provided by a registered professional nurse or a licensed practical nurse licensed to practice in this state. Nursing through the HCBS waiver focuses on long-term habilitative needs rather than short-term acute, restorative needs. HCBS waiver intermittent nursing services are in addition to any Medicaid state plan nursing services for which the Member may qualify.

Therapies—Service provided by a licensed therapist that meets Illinois standards. Services are in addition to any Medicaid state plan services for which the Member may qualify. Therapies through the waiver focus on long-term habilitative needs rather than short-term acute, restorative needs.

Prevocational Services—Prevocational services are aimed at preparing a Member for paid or unpaid employment but are not job-task oriented. This can include teaching concepts such as compliance, attendance, task completion, problem solving, and safety. Prevocational services are provided to Members expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

Assisted Living (Supportive Living)—The Supportive Living Program serves as an alternative to Nursing Facility (NF) placement, providing an option for seniors 65 years of age or older and persons with physical disabilities between the ages of 22 and 64 who require assistance with activities of daily living, but not the full medical model available through a nursing facility. Members reside in their own private apartment with kitchen or kitchenette, private bath, individual heating and cooling system, and lockable entrance.

Behavioral Health Services (M.A. and Ph.D.)—Remedial therapies to decrease maladaptive behaviors and/or to enhance the cognitive functioning of the Member to increase their capacity for independent living.

LTSS Services by Waiver Program

Benefit	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Facility
Adult Day Health (ADH)	X	X	X	X	
Adult Day Health (ADH) Transportation	X	X	X	X	
Assisted Living (Supportive Living)					X
Automatic Medication Dispenser (AMD)	X				
Behavioral Health Services (M.A. and Ph.D.)				X	
Day Habilitation				X	
Environmental Accessibility Adaptations		X	X	X	
Home Delivered Meals		X	X	X	
Home Health Aide		X	X	X	
Homemaker Services	X	X	X	X	
Nursing, Intermittent		X	X	X	
Personal Care Services (Individual Provider)		X	X	X	
Prevocational Services				X	
Respite		X	X	X	
Skilled Nursing Services (LPN)		X	X	X	
Skilled Nursing Services (RN)		X	X	X	
Specialized Medical Equipment and Supplies		X	X	X	
Supported Employment				X	
Therapies		X	X	X	

Getting Care, Getting Started
Molina Care Coordinators will engage with Members and routinely assess for barriers and opportunities to coordinate medical, behavioral health, and LTSS services. Specifically, along with providing the fully integrated Individualized Plan of Care (IPoC), the Care Coordinator will provide verbal, written, and/or alternate format information on:

- After-hours assistance for urgent situations.
- Access to timely appointments.
- Accommodations available to meet individual linguistic, literacy, and preferred modes of communication.
- Advocacy, engagement of family members, and informal supports.

At a minimum, the Care Coordinator's name, contact information, and hours of availability are included in the care plan, which is shared with all Interdisciplinary Care Team (ICT) participants based on a Member's recorded preferences. All Care Coordinators are required to keep email and voicemail current with availability or backup as necessary for Members and their Providers.

Molina will ensure the provision of the following service coordination services for Members:

- LTSS service coordination.
- Care and Service Plan review.
- Crisis intervention.
- Event-based visits.
- Institution-based visits.
- Service management.
- Medicaid resolution.
- Assessment of LTSS need.
- Member education.

Molina will work closely with the various Community Based Organizations (CBOs) for Home and Community-Based Services (HCBS) to ensure that the Member is getting the care that he or she needs.

Once you have been identified as the Provider of service, it will be your responsibility for billing of these services. The Individualized Care Plan (ICP) will document services, duration, and any other applicable information.

Care Management Team, Integrated Care Team, Interdisciplinary Care Team (ICT)
All LTSS Members will receive care coordination and be assigned a Care Coordinator from Molina.

The Care Management team for LTSS will include at a minimum the Member and/or his/her authorized representative, Care Coordinator, and PCP.

The patient-centered Integrated Care Team (ICT) will include at minimum the Member and/or his/her authorized representative, Care Coordinator, and anyone a Member

requests to participate. ICT Members may also include LTSS Providers (e.g., Services Facilitator, adult day health care center staff, assistive technology, transition coordinator, nursing facility staff, etc.), PCP, specialist(s), behavioral health clinician, targeted case management service Providers, and pharmacist. The ICT can also include family/caregivers, peer supports, or other informal supports and is not limited to the list of required Members.

Individualized Care Plan Coordination
LTSS services to be covered by Molina will require coordination and approval.

The Individualized Care Plan (ICP) includes the consideration of medical, behavioral, and long-term care needs of the Member identified through a patient-centered assessment process. The ICP includes informal care, such as family and community supports. Molina Healthcare of Illinois will ensure that a patient-centered service plan is implemented for the Member in compliance with the Department of Health and Human Services HCBS final rule section 441.301.

A patient-centered service plan means that the plan documents the amount, duration, and scope of the Home and Community-Based Services. The service plan is patient-centered and must reflect the services and supports that are important for the Member to meet his/her needs, goals, and preferences that are identified through an assessment of functional need. The service plan will also identify what is important with regard to the delivery of these services and supports (42 CFR 441.301).

The Individualized Care Plan (ICP) will be developed under the Member's direction and implemented by assigned members of the Interdisciplinary Care Team (ICT) no later than the end date of any existing Service Authorization (SA) or within the state-specific time frames for initial assessments and reassessments. All services and changes to services must be documented in the ICP and be under the direction of the Member in conjunction with the Care Coordinator.

The Integrated Care Team (ICT) under the Member's direction, is responsible for developing the ICP, and is driven by and customizable according to the needs and preferences of the Member. As a Provider, you may be asked to be a part of the ICT.

Additional services can be requested through the Member's Care Coordinator any time, including during the assessment process and through the ICT process. Additional needed services must be at the Member's direction and can be brought forward by the Member, the Care Manger, and/or the ICT team as necessary. Once an additional need is established, the ICP will be updated with the Member's consent and additional services approved. For additional information regarding LTSS service coordination and approvals in the Member's ICP, please contact Molina at **(855) 687-7861**.

Transition of Care (TOC) Programs
Molina has goals, processes, and systems in place to ensure smooth transitions between a Member's setting of care and level of care. This includes transitions to and from inpatient settings (i.e., Nursing Facility to home).

All Care Coordinators are trained on the Transitions of Care approach that Molina follows for transitions between care settings. The Care Coordinators can use tablet technology housed in an electronic health-management platform to facilitate on-site, in-person, and home-based assessments.

Continuity of Care (COC) Policy and Requirements
Molina will allow for the safe transition of Members while adhering to minimal service disruption. In order to minimize service disruption, Molina will honor the Member's existing service plans, level of care, and Providers (including out-of-network Providers) for 90 days.

Ongoing Provider support and technical assistance will be provided, especially to community behavioral health, LTSS Providers, and out-of-network Providers during the COC period. All existing Integrated Care Plans (ICPs) and Service Authorizations (SAs) will be honored during the transition period of 90 days.

A Member's existing Provider may be changed during the 90-day transition period only in the following circumstances: (1) the Member requests a change, (2) the Provider chooses to discontinue providing services to a Member as currently allowed by Medicaid, (3) Molina or HFS identifies Provider performance issues that affect a Member's health or welfare, or (4) the Provider is excluded under state or federal exclusion requirements.

Out-of-network Providers who are providing services to Members during the initial COC period shall be contacted to provide them with information on becoming credentialed, in-network Providers. If the Provider chooses not to join the network, or the Member does not select a new in-network Provider by the end of the 90-day transition period, Molina will work with the Member to select an in-network Provider.

Members in a Nursing Facility (NF) at the time of Molina LTSS enrollment may remain in that NF as long as the Member continues to meet Nursing Facility level of care, unless they, their family, or authorized representative prefer to move to a different NF or return to the community. The only reasons for which Molina may require a change in NF is if (1) Molina or HFS identifies Provider performance issues that affect a Member's health or welfare, or (2) the Provider is excluded under state or federal exclusion requirements.

Reassessments will be completed as necessary and IPoCs updated. Molina will review IPoCs of high-risk (Level 3) Members at least every 30 days, and moderate-risk (Level 2) Members at least every 90 days, and conduct reassessments as needed based upon such reviews. At a minimum, a health-risk reassessment will be conducted annually for each Member who has an IPoC. In addition, a face-to-face health-risk reassessment will

be conducted for Members receiving HCBS waiver services or residing in NFs each time there is a significant change in the Member's condition or a Member requests reassessment. The updated IPoCs will be given to Providers that are involved in providing Covered Services to Members within no more than five (5) business days.

For additional information regarding Continuity of Care and transition of LTSS Members, please contact Molina at **(855) 687-7861**.

Members have a choice of how their services are delivered through various models, which may include consumer direction. The Molina Care Coordinator will work with the Member or his/her designee to ensure that the Member meets the criteria for consumer direction.

Claims for LTSS Services
Providers are required to bill Molina for all services.

- Long-term care claims **must** be billed electronically.
- Waiver-related claims are accepted electronically through the EDI platform, through our Portal, and by mail. Register for the Provider Portal here: Provider Self Services Portal.

Billing Molina
For detailed billing information, see the appendices at the end of this section.

All HCBS waiver services, with the exception of personal care workers, are billing to Molina on a professional claim form. A listing of codes, units, services, and taxonomy numbers is at the end of the document. In the absence of an NPI, Providers should bill with their 12-digit HFS Provider ID specifically related to the waiver service. For example, if services are for a Member on the elderly waiver, bill using the HFS Provider number registered for Provider type 090.

Long-term care claims are billed on an 837I and **require** several key data elements, including but not limited to:

- Original admission date.
- Taxonomy codes (provided in the billing guidelines).
- Value code 80 for all covered days
- Value code 81 for all non-covered days
- Be mindful of bill type, especially for interim bills.
- All claims are subject to our patient credit file validation process and the application of any Member liability.

Atypical Providers
Atypical Providers are service Providers that do not meet the definition of health care Provider. Examples include Adult Day Care, Respite Care, and Homemaker Services. Although they are not required to register for an NPI, these Providers perform services that are reimbursed by Molina Healthcare of Illinois.

When billing Molina for LTSS Services as an atypical Provider, refer to the Appendix for more detailed information.

Timely Filing Processing
Standard timely filing is 180 days for Medicaid.

Claims Submission: Online Provider Portal
We encourage our LTSS Providers to utilize the Provider Portal to submit claims. Please see the Claims and Compensation section of this manual or the Portal Quick Reference Guide for further details. You may also contact your Provider Network Manager or email the Provider Network Management team at MHILProviderNetworkManagement@MolinaHealthcare.com.

Timely Claims Processing
Typically, claims are processed within 30 days.

Billing Molina Members
Providers may **not** bill Members. **Balance billing is not allowed.** There is no Member liability, except for Members in a custodial long-term care setting. Members who are living in a long-term care facility, Specialized Mental Health Rehabilitation Facility (SMHRF), Intermediate Care Facility/Mental Illness (ICF/MI), or a Supportive Living Facility (SLF) may have a cost-share related to their income. The state determines the Member's income and patient liability. That information is shared with Molina via the patient credit file.

For the claim to be considered for payment, the Member must be on the patient credit file for the dates of service, and the Provider billing must also be on the patient credit file. This includes both the LTC Provider and, when applicable, the hospice Provider if the Member is in an LTC facility and receiving hospice services.

Any Member income will be subtracted from the room-and-board charge line and for SLF from the ancillary services (revenue code 0240). For Members living in an LTC facility receiving hospice-related services, the income will be reduced from the room-and-board charges (revenue code 0658).

Provider Claims Dispute (Adjustment Request)
A request to review the processing, payment, or non-payment of a claim by Molina shall be classified as a Provider Claim Dispute and can be submitted through one of the following options:

- Provider Portal—Providers are strongly encouraged to use the online Portal to submit Provider Claims Disputes.
- Fax—Provider Claims Disputes can be faxed to Molina at **(855) 502-4962**. Must also contain a completed Claims Dispute Form.
- **Note**—CDs containing medical records may be sent to Molina Healthcare of Illinois, Inc., Attention: Provider Disputes, 1520 Kensington Rd., Suite 212, Oak Brook IL 60523. Must also include completed Claims Dispute Form.
- **Important**—Please submit only one (1) claim per dispute.

Provider Complaints
Providers must follow the current Conditions of Participation and Service Specification requirements of the Medicaid waiver(s) for which they are certified/approved. Each entity that pays claims will review Provider's documentation to verify that services authorized and paid for are actually provided. Providers must work with Molina first before submitting complaints to the state agency.

Providers have the right to file a complaint if they are dissatisfied with any aspect of operation or service rendered by Molina that does not pertain to a benefit or claim determination. Complaints may be submitted no later than 30 calendar days from the date the Provider becomes aware of the issue generating the complaint.

Appendix 1: Home and Community-Based Services (HCBS) Codes

Service	Code	Modifier	Unit/Billing Increment	Taxonomy*
Adult Day Care	S5100		15 minutes	261QA0600X
Adult Day Care Transportation	T2003		1 unit = one-way trip	261QA0600X
Agency Services CNA	T1004		15 minutes	251E00000X 251J00000X
Agency Services – Individualized service provided to more than one patient in the same setting	T1002	TT	15 minutes	251E00000X 251J00000X 282N00000X 253Z00000X
Agency Services – LPN	T1003		15 minutes	251E00000X 251J00000X 282N00000X 253Z00000X
Agency Services – RN	T1002		15 minutes	251E00000X 251J00000X 282N00000X 253Z00000X
Automatic Medication Dispenser	A9901		Per install	332B00000X
Automatic Medication Dispenser – Monthly	T1505		Per month	332B00000X
Behavioral Services – Doctoral Level (PHD)	H0004	HP	Per visit, 1-hour max	251S00000X
Behavioral Services – Master's Degree Level (MA)	H0004	HO	Per visit, 2-hour max	251S00000X
Home-Delivered Meals	S5170		2 meals = 1 unit Max = 1 unit per day	332U00000X
Home Modification	S5165		Varies with services, max $25,000.00 in a five-year period	171WH0202X 171W00000X
Homemaker	S5130		15 minutes	376J00000X 251E00000X
Occupational Therapy	G0152		15 minutes, max = 4 hours per day	225X00000X 251E00000X
Personal Emergency Response – Install	S5160		Per install	146D00000X 3333300000X
Personal Emergency Response –Monthly	S5161*	**	Per month	146D00000X 333300000X
Physical Therapy	G0151		15 minutes, max = 4 hours per day	225100000X 251E00000X
Prevocational Services	T2014		Per diem	251S00000X 251E00000X
Respite Adult Day Care	T1005	HQ	15 minutes	261QA0600X 385H00000X
Respite Adult Day Care – Transportation	T1005	HB	1 unit = 1 trip Max = 2 daily	261QA0600X 385H00000X
Respite Agency Services Home Health Aide (CNA)	T1005	SC	15 minutes	385H00000X 376J00000X 251E00000X
Respite Agency Services – LPN	T1005	TE	15 minutes	385H00000X 376J00000X 251E00000X

Service	Code	Modifier	Unit/Billing Increment	Taxonomy*
Respite Agency Services – RN	T1005	TD	15 minutes	385H00000X 376J00000X 251E00000X
Respite Homemaker	T1005	SE	15 minutes	385H00000X 376J00000X
Specialized Medical Equipment/Supplies – Purchase	T2028		Per service	332B00000X
Specialized Medical Equipment/Supplies – Rental	T2028	RR	Per service, max $1,225 per month	332B00000X
Speech Therapy	G0153		Per visit, 4 hours max	235Z00000X 251E00000X
Speech Therapy – Services Delivered Under an Outpatient Hospital Speech Language Pathology Plan of Care	G0153	GN	Per visit	235Z00000X 282N00000X
Supported Employment No Job Coach Individual	T2019		1 unit = 1 hour	251S00000X 261QR0400X 251E00000X
TBI Day Habilitation	T2020		Per diem	261QR0400X 373H00000X 251E00000X

* Other taxonomy numbers may be accepted. However, these are the recommended codes for Molina.

** Exception for Molina: When services are provided on a cellular platform vs. a landline, S5161 should include the U2 modifier.

Appendix 2: Nursing Facility Billing Guidance

Nursing Facility claims can only be submitted via the 837I (electronic/EDI submission). The Nursing Facility Billing Guidance for Illinois are listed below.

Bill Type FL 04	Bill Type Description	Inpatient or Outpatient	Legacy Cos	Legacy Cos Description	Revenue Code FL 42	Revenue Code Description	Occurrence Code FL 31-34	Occurrence Span Code FL 35-36	Value Code FL 39-41	Value Code Description
Provider Type 028 Alzheimer/Dementia Center Taxonomy Code: 311500000X										
089X	Special Facility - Other	OP	86	LTC SLF Dementia Care	0240	All Inclusive Ancillary/General		N/A	80	Covered Days
089X	Special Facility - Other	OP	86	LTC SLF Dementia Care	0182 0183 0185	Patient Convenience Therapeutic Leave Hospitalization		74	81	Non-Covered
Provider Type 028 Assisted Living Facility Taxonomy Code: 310400000X										
089X	Special Facility - Other	OP	87	LTC - Supportive Living Facility (Waivers)	0240	All Inclusive Ancillary/General		N/A	80	Covered Days
089X	Special Facility - Other	OP	87	LTC - Supportive Living Facility (Waivers)	0182 0183 0185	Patient Convenience Therapeutic Leave Hospitalization		74	81	Non-Covered
Provider Type 033 Skilled Nursing Facility Taxonomy Code: 314000000X										
021X 022X	Skilled Nursing Inpatient (Including Medicare Part A) Skilled Nursing Facilities - (Inpatient Part B)	IP	70	LTC - Skilled	0110 - 0160*	General Room & Board Values	***If Recipient Has Medicare Part A*** A2 - Eff. Date of Medicaid A3 - Benefits Exhausted B3 - Benefits Exhausted - Payer B 22 - Date Active Care Ended 25 - Date Benefits Terminated	N/A	80	Covered Days
021X 022X	Skilled Nursing Inpatient (Including Medicare Part A) Skilled Nursing Facilities - (Inpatient Part B)	IP	70	LTC - Skilled	0182 0183 0185	Patient Convenience Therapeutic Leave Hospitalization		74	81	Non-Covered
065X	Intermediate Care - Level I	IP	71	LTC - Intermediate	0110 - 0160*	General Room & Board Values		N/A	80	Covered Days
065X	Intermediate Care - Level I	IP	71	LTC - Intermediate	0182 0183 0185	Patient Convenience Therapeutic Leave Hospitalization		74	81	Non-Covered

Provider Type 033 Skilled Nursing Facility Taxonomy Code: 314000000X										
021X 022X	Skilled Nursing Inpatient (Including Medicare Part A) Skilled Nursing Facilities - (Inpatient Part B)	IP	**65	LTC Full Medicare Coverage	0110 - 0160*	General Room & Board Values		70	80	Covered Days
021X 022X	Skilled Nursing Inpatient (Including Medicare Part A) Skilled Nursing Facilities - (Inpatient Part B)	IP	**72	LTC-NF Skilled-Co-Ins (partial Medicare coverage)	0110 - 0160*	General Room & Board Values		70	82	Co Ins. Days
021X 022X	Skilled Nursing Inpatient (Including Medicare Part A) Skilled Nursing Facilities - (Inpatient Part B)	IP	38	Exceptional Care - TBI Level I Exceptional Care - TBI Level II Exceptional Care - TBI Level III Exceptional Care - VENT	0191 0192 0193 0194	Subacute Care - Level I Subacute Care - Level II Subacute Care - Level III Subacute Care - Level IV		N/A	80	Covered Days
079X	Clinic-Other	OP	083	Developmental Training	0942	Education/Training				
Provider Type 033 Nursing Facility / Intermediate Care Facility Taxonomy Code: 314000000x										
065X	Intermediate Care - Level I	IP	71	LTC - Intermediate	0110 - 0160*	General Room & Board Values		N/A	80	Covered Days
065X	Intermediate Care - Level I	IP	71	LTC - Intermediate	0182 0183 0185	Patient Convenience Therapeutic Leave Hospitalization		74	81	Non-Covered
079X	Clinic-Other	OP	083	Developmental Training	0942	Education/ Training		N/A		
Provider Type 033 General Acute Care Hospital (LTC wing) Taxonomy Code: 282N00000X										
011X 021X	Hospital Inpatient (Including Medicare Part A) Skilled Nursing Inpatient (Including Medicare Part A)	IP	70	LTC - Skilled	0110 - 0160*	General Room & Board Values	***If Recipient Has Medicare Part A*** A2 - Eff. Date of Medicaid A3 - Benefits Exhausted B3 - Benefits Exhausted - Payer B 22 - Date Active Care Ended 25 - Date Benefits Terminated	N/A	80	Covered Days
011X 021X	Hospital Inpatient (Including Medicare Part A) Skilled Nursing Inpatient (Including Medicare Part A)	IP	70	LTC - Skilled	0182 0183 0185	Patient Convenience Therapeutic Leave Hospitalization		74	81	Non-Covered

Provider Type 033 General Acute Care Hospital (LTC wing) Taxonomy Code: 282N00000X										
021X	Skilled Nursing Inpatient (Including Medicare Part A)	IP	**65	LTC Full Medicare Coverage	0110 - 0160*	General Room & Board Values		70	80	Covered Days
021X	Skilled Nursing Inpatient (Including Medicare Part A)	IP	**72	LTC-NF Skilled-Co-Ins (partial Medicare coverage)	0110 - 0160*	General Room & Board Values		70	82	Co Ins. Days
021X 022X	Skilled Nursing Inpatient (Including Medicare Part A) Skilled Nursing Facilities - (Inpatient Part B)	IP	38	Exceptional Care - TBI Level I Exceptional Care - TBI Level II Exceptional Care - TBI Level III Exceptional Care - VENT	0191 0192 0193 0194	Subacute Care - Level I Subacute Care - Level II Subacute Care - Level III Subacute Care - Level IV		N/A	80	Covered Days
065X	Intermediate Care - Level I	IP	71	LTC - Intermediate	0110 - 0160*	General Room & Board Values		N/A	80	Covered Days
065X	Intermediate Care - Level I	IP	71	LTC - Intermediate	0182 0183 0185	Patient Convenience Therapeutic Leave Hospitalization		74	81	Non-Covered
079X	Clinic-Other	OP	083	Developmental Training	0942	Education/ Training		N/A		
Provider Type 038 Intermediate Care Facility, Mental Illness Taxonomy Code: 310500000X										
065X	Intermediate Care - Level I	IP	71	LTC - Intermediate	0110 - 0160*	General Room & Board Values		N/A	80	Covered Days
065X	Intermediate Care - Level I	IP	71	LTC - Intermediate	0182 0183 0185	Patient Convenience Therapeutic Leave Hospitalization		74	81	Non-Covered
					* Except for 0115, 0125, 0135, 0145 or 0155		1.			

Notes: ** When billing Medicare Covered services directly claim must include the Other Payer Loop showing the Medicare TPL code 909 and the Medicare adjudication information
The Occurrence Span Code (70) showing the Qualifying Stay is not required by HFS but can be reported on direct billed claims for Medicare Covered services
If Recipient Has Medicare Part A and Medicaid covered services are being billed an Occurrence Code showing Medicare benefit end date or Medicaid coverage begin date must be included on the claim

5. Enrollment, Eligibility, and Disenrollment

Enrollment
Enrollment in Medicaid Programs
The Illinois Medical Assistance Program implements Title XIX of the Social Security Act (Medicaid). HFS administers Medicaid under the Illinois Public Aid Code. Through an interagency agreement with HFS, the Illinois Department of Human Services (DHS) takes applications and determines the eligibility of individuals and families for HFS medical programs.

To apply for HFS medical benefits, an individual, a representative, or the responsible parent or guardian must complete and submit an application to DHS. This can be done by visiting the nearest DHS office, or where health reasons prohibit visiting an office, by contacting DHS to have an application mailed. Mailed applications are followed by a telephone interview. It is also possible to enroll for HFS medical benefits through the DHS website.

DHS can be contacted at:

DHS website: dhs.state.il.us/page.aspx
Toll Free at: (800) 843-6154
TTY: (866) 324-5553

Illinois Client Enrollment Services (ICES) and HFS Health Plan Assignment
HFS clients who are among eligible populations and living in counties with authorized health plans are eligible to enroll in and receive services from Molina. Individuals must contact Illinois Client Enrollment Services (ICES) to select Molina as their health plan. Molina participates in the following HFS programs:

- HealthChoice Illinois Managed Long-Term Services and Supports (MLTSS), effective January 1, 2018.
- HealthChoice Illinois, effective January 1, 2018.
- Special Needs Children, effective February 1, 2020.

ICES can be contacted at:

ICES website: enrollhfs.illinois.gov
Toll Free at: (877) 912-8880
TTY: (866) 565-8576

ICES assists eligible Medicaid Enrollees with selecting a health plan of their choice. If Enrollees do not choose a plan, ICES will passively assign the Enrollee through auto-assignment to a plan that services the area where the Member resides.

No eligible Member shall be refused enrollment or re-enrollment, have his/her enrollment terminated, or be discriminated against in any way because of their health status, pre-existing physical or mental condition, including pregnancy, hospitalization, or the need for frequent or high-cost care.

Effective Date of Enrollment
When initially applying for coverage, HFS applicants may request that their coverage is backdated to cover services they may have already received for up to three months prior to the month of their application. HFS will designate coverage to begin on the first day of a calendar month no later than three calendar months from the date HFS accepts the enrollment in its database.

Newborn Enrollment
Enrollment of newborns, infants, and children who are added to the case of the mother whose Recipient Identification Number (RIN) is on the Integrative Emergency Services (IES) transaction and who is enrolled with the Molina Healthcare, are enrolled automatically as follows:

- If the newborn is added to the case before the newborn is 46 days of age, the newborn's effective enrollment date with Molina is retroactive to the newborn's date of birth.
- Molina will provide coverage of the newborn Enrollee retroactively to the date of birth, based on the enrollment effective date determined by the department.
- Molina will not require prior authorization for inpatient newborn claims for newborns retroactively enrolled pursuant to this section.

Enrollment of newborns, infants, and children who are added to the case of the mother whose RIN is on the IES transaction and who is enrolled with Molina, are enrolled automatically as follows: If an infant is added to the case after the age of 45 days and up to, but not including, one (1) year of age, the newborn's effective enrollment date with Molina will be prospective. Molina will provide coverage of the infant Enrollee prospectively, based on the effective enrollment date determined by the department.

Children under the age of 19, excluding newborns and infants, who are added to the case of a sibling, mother, or head of household and whose RIN is on the IES transaction and who is enrolled with Molina, are enrolled automatically. Molina will provide coverage of the child Enrollee prospectively.

For newborn claims where newborn has not yet been determined Medicaid eligible and assigned a RIN, Molina will follow the claims processing rules for newborns not yet assigned a RIN established by the department for fee-for-service claims.

Inpatient at Time of Enrollment
Regardless of what program or health plan the Member is enrolled in at discharge, the program or plan the Member is enrolled with on the date of admission shall be responsible for payment of all covered inpatient facility and professional services provided from the date of admission until the date the Member is no longer confined to an acute care hospital. Exception: This would not apply if the hospital is per diem.

Eligibility Verification
Medicaid Programs
HFS determines eligibility for Medicaid Programs. Payment for services rendered is based on eligibility and benefit entitlement. The contractual agreement between

Providers and Molina places the responsibility for eligibility verification on the Provider of services.

Eligibility Listing for Medicaid Programs
HFS Providers can verify eligibility and health plan assignment for HFS recipients through the Medical Electronic Data Interchange (MEDI) system. MCO health plan effective dates are **always the first of the month.**

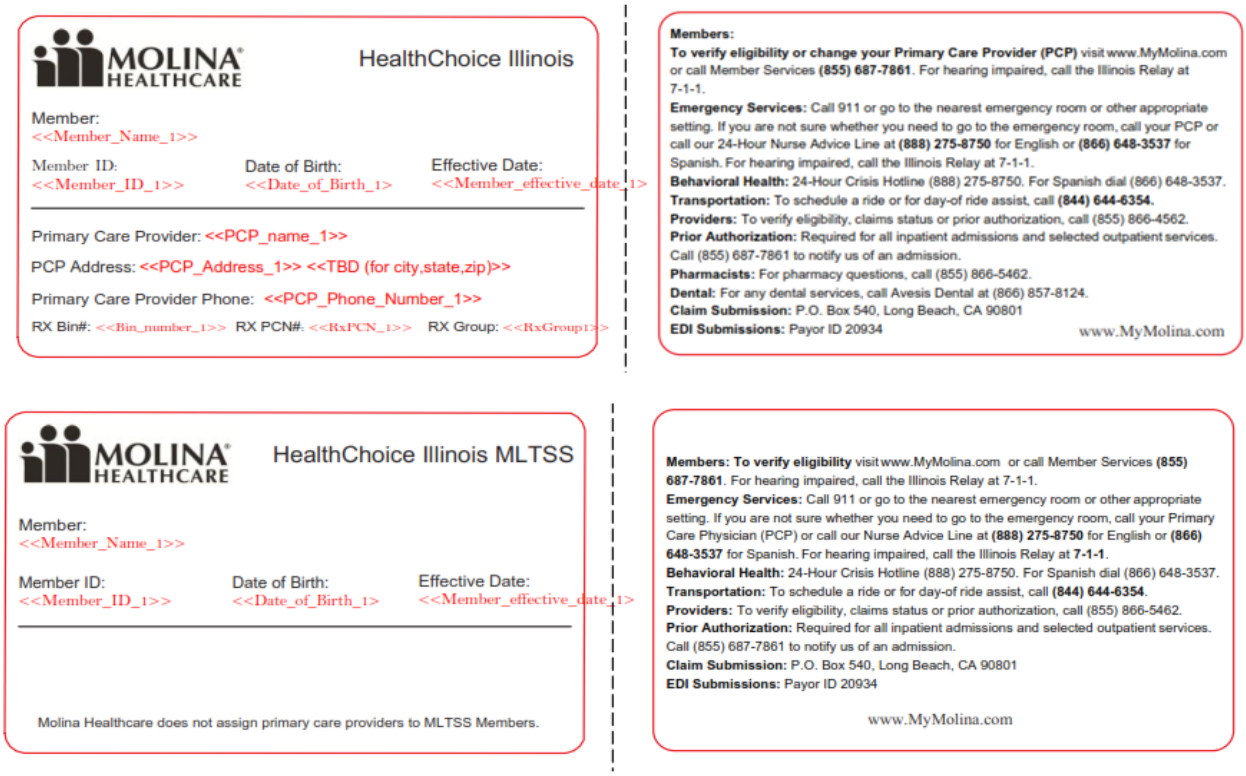
MEDI is a free, secure website. Providers can register for MEDI and create their login and password at: myhfs.illinois.gov. Providers can also verify HFS eligibility and MCO health plan assignment on the phone by calling the HFS Automated Voice Response System at **(800) 842-1461**.

Molina Member Eligibility Verification
Providers who contract with Molina may verify a Member's eligibility and/or confirm PCP assignment by checking the following:

- Member Services at **(855) 687-7861**.
- Portal at provider.molinahealthcare.com.

Possession of a Medicaid ID Card does not mean a recipient is eligible for Medicaid services. **Providers should verify a recipient's eligibility each time the recipient receives services.** The verification sources can be used to verify a recipient's enrollment in a managed care plan. The name and telephone number of the managed care plan are given along with other eligibility information.

Identification Cards
Molina Sample Member ID card



Members are reminded in their Member Handbooks to carry ID cards with them when requesting medical or pharmacy services. It is the Provider's responsibility to ensure Molina Members are eligible for benefits and to verify PCP assignment **prior to** rendering services. Unless an emergency medical condition exists, Providers may refuse service if the Member cannot produce the proper identification and eligibility cards.

Disenrollment
Voluntary Disenrollment

When an Enrollee is subject to mandatory managed care enrollment under the Medicaid Managed Care Program, an Enrollee may request to disenroll for any of the following reasons at any time by notifying Molina, orally or in writing, of the Enrollee's request to disenroll. The request will be granted by the Department of Healthcare and Family Services when the reason matches any of the following (as determined by the department):

- The Enrollee moves out of the contracting area.
- Molina, due to its exercise of right of conscience, does not provide the covered service that the Enrollee seeks.
- The Enrollee needs related covered services to be performed at the same time, not all the related services are available through Molina, and the Enrollee's Provider determines that receiving the services separately would subject the Enrollee to unnecessary risk.

- When a change in Enrollee's LTSS Provider (residential, institutional, or employment support) from a network Provider to a non-network Provider results in a disruption to residence or employment.
- Other reasons, including poor quality of care, a sanction imposed by the department, lack of access to covered services, lack of access to Providers experienced in dealing with the Enrollee's health care needs, or if the Enrollee is automatically re-enrolled and such loss of coverage causes the Enrollee to miss the open enrollment period.

Voluntary disenrollment does not preclude Members from filing a grievance with Molina for incidents occurring during the time they were covered.

Involuntary Disenrollment
The department will terminate an Enrollee's coverage when the Enrollee becomes ineligible for HFS Medical Program or otherwise is not within the population described as being Enrollees under this contract or upon the occurrence of any of the following conditions:

- Upon the Enrollee's death. Termination of coverage will take effect at 11:59 p.m. on the last day of the month in which the Enrollee dies. Termination may be retroactive to this date.
- When an Enrollee elects to change MCOs during the change period or open-enrollment period. Termination of coverage with the previous MCO will take effect at 11:59 p.m. on the day immediately preceding the Enrollee's effective enrollment date with the new MCO.
- When an Enrollee no longer resides in the contracting area. If an Enrollee is to be disenrolled at Molina's request, Molina must first provide documentation satisfactory to the department that the Enrollee no longer resides in the contracting area. Termination of coverage will take effect at 11:59 p.m. on the last day of the month prior to the month in which the department determines that the Enrollee no longer resides in the contracting area. Termination may be retroactive if the department is able to determine the month in which the Enrollee moved from the contracting area.
- When the department determines that an Enrollee has other significant insurance coverage or is placed in spend-down status. The department will notify Molina of such disenrollment. This notification will include the effective disenrollment date.
- When the department is made aware that an Enrollee is incarcerated in a county jail, Illinois Department of Corrections facility, or federal penal institution. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month prior to the month in which the Enrollee was incarcerated.
- When an Enrollee enters DCFS custody. Termination of coverage shall take effect at 11:59 p.m. on the day prior to the day on which the court grants DCFS custody of the Enrollee.

PCP Dismissal
A PCP may dismiss a Member from their practice based on standard, written office policies. PCPs must document the reasons for dismissal, which may include:

- A Member who continues not to comply with a recommended plan of health care. Such requests must be submitted at least 60 calendar days prior to the requested effective date.
- A Member whose behavior is disruptive, unruly, abusive, or uncooperative to the extent that their enrollment with the PCP seriously impairs the PCP's ability to furnish services to either the Member or other patients. This section does not apply to Members with mental health diagnoses if the Member's behavior is attributable to the mental illness.

This section does not apply if the Member's behavior is attributable to a physical or behavioral condition.

Missed Appointments
The Provider will document and follow up on appointments missed and/or canceled by the Member. Providers should notify Molina when a Member misses two consecutive appointments. Members who miss three consecutive appointments within a six-month period may be considered for disenrollment from a Provider's panel. Such a request must be submitted at least 60 calendar days prior to the requested effective date.

PCP Assignment
Illinois Client Enrollment Services (ICES) is responsible for all initial health plan and PCP assignments for HFS medical programs. HFS clients can voluntarily enroll in a health plan and select their PCP online at enrollhfs.illinois.gov/enroll or via phone at **(877) 912-8880**. HFS clients who do not select a health plan and PCP will have one chosen for them through auto-assignment.

Molina will offer each Member a choice of PCPs. After making a choice, each Member will have a single PCP. Molina will allow pregnant Members to choose the health plan's obstetricians as their PCPs to the extent that the obstetrician is willing to participate as a PCP. Providers shall advise all Members of the Members' responsibility to notify Molina and HFS of their pregnancies and the births of their babies.

The ICES will work to re-enroll a Member into the health plan in which he or she was most recently enrolled if the Member has a temporary loss of HFS eligibility, defined as less than 60 calendar days.

PCP Changes
Members may change their PCP designations at any time with the change being effective on the first day of the month following the date of the Member's request.

Members who wish to change their PCP designations may call Molina Member Services at **(855) 687-7861**. Members may also manage their health care any time via the Member Portal available at MyMolina.com. Members may use the Member Portal to change their PCP, update their contact information, request a new ID card, and view service history.

6. Member Rights and Responsibilities

Providers must comply with the rights and responsibilities of Molina Members as outlined in the Molina Member Handbook and on the Molina website. The Member Handbook that is provided to Members annually is hereby incorporated into this Provider Manual. The most current Member Rights and Responsibilities can be accessed via the following link: molinahealthcare.com/members/il/en-US/PDF/Medicaid/member-handbook-healthchoice-illinois.pdf

Member Handbooks are available on Molina's Member Website. Member Rights and Responsibilities are outlined under the heading "Rights and Responsibilities" within the Member Handbook document.

State and federal law require that health care Providers and health care facilities recognize Member rights while the Members are receiving medical care, and that Members respect the health care Provider's or health care facility's right to expect certain behavior on the part of the Members.

For additional information, please contact Molina Healthcare at **(855) 687-7861**, 8 a.m. to 5 p.m. Central Time, Monday through Friday, excluding state and federal holidays. TTY users, please call 711.

Second Opinions
If Members do not agree with their Provider's plan of care, they have the right to a second opinion from another Provider. Members should call Member Services to find out how to get a second opinion. Second opinions may require Prior Authorization.

7. Health Care Services (HCS)

Introduction
Health Care Services is comprised of Utilization Management (UM) and Care Management (CM) departments that work together to achieve an integrated model based upon empirically validated best practices that have demonstrated positive results. Research and experience show that a higher touch, Member-centric care environment for at-risk Members supports better health outcomes. Molina provides care management services to Members to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services. Elements of the Molina Utilization Management Program include pre-service authorization review and inpatient authorization management that includes pre-admission, admission and concurrent review, Medical Necessity review, and restrictions on the use of out-of-network Providers.

Utilization Management (UM)
Molina ensures the service delivered is Medically Necessary and demonstrates an appropriate use of resources based on the level of care needed for a Member. This program promotes the provision of quality, cost-effective, and medically appropriate services that are offered across a continuum of care, as well as integrating a range of services appropriate to meet individual needs.

It maintains flexibility to adapt to changes in the Member's condition and is designed to influence Member's care by:

- Managing available benefits effectively and efficiently while ensuring that quality care is provided.
- Evaluating the Medical Necessity and efficiency of health care services across the continuum of care.
- Defining the review criteria, information sources, and processes that are used to review and approve the provision of items and services, including prescription drugs.
- Coordinating, directing, and monitoring the quality and cost-effectiveness of health care resource utilization.
- Implementing comprehensive processes to monitor and control the utilization of health care resources.
- Ensuring that services are available in a timely manner, in appropriate settings, and are planned, individualized, and measured for effectiveness.
- Reviewing processes to ensure care is safe and accessible.
- Ensuring that qualified health care professionals perform all components of the UM and CM processes.
- Ensuring that UM decision-making tools are appropriately applied in determining Medical Necessity decision.

Key Functions of the UM Program
The following table outlines the key functions of the UM Program. All Prior Authorizations are based on a specific standardized list of services.

Eligibility and Oversight	Resource Management	Quality Management
Eligibility verification	Prior Authorization and referral management	Satisfaction evaluation of the UM Program using Member and Provider input
Benefit administration and interpretation	Pre-admission, admission, and inpatient review	Utilization data analysis
Ensure authorized care correlates to Member's Medical Necessity need(s) & benefit plan	Post service/post claim audits	Monitor for possible over- or under-utilization of clinical resources
Verifying current physician/hospital contract status	Referrals for discharge planning and care transitions	Quality oversight
Delegation oversight	Staff education on consistent application of UM functions	Monitor for adherence to CMS, NCQA, state and health plan UM standards

This Molina Provider Manual contains excerpts from Molina's Health Care Services Program description. For a complete copy of the state's Health Care Services Program description, you can access the Molina website or contact the UM department to receive a written copy. You can always find more information about Molina's UM Program—including information about obtaining a copy of clinical criteria used for authorizations and how to contact a UM reviewer—on Molina's website or by calling the UM department.

Medical groups/IPAs and delegated entities who assume responsibility for UM must adhere to Molina's UM Policies. Their programs, policies, and supporting documentation are reviewed by Molina at least annually.

UM Decisions
A decision is any determination (e.g., an approval or denial) made by Molina or the delegated Medical Group/Independent Physician Association (IPA) or other delegated entity with respect to the following:

- Determination to authorize, provide, or pay for services (favorable determination).
- Determination to deny payment of request (adverse determination).
- Discontinuation of a payment for a service.
- Payment for temporarily out-of-the-area renal dialysis services.
- Payment for Emergency Services, post-stabilization care, or urgently needed services.

Molina follows a hierarchy of Medical Necessity decision-making, with federal and state regulations taking precedence. Molina covers all services and items required by state and federal regulations.

Board-certified, licensed Providers from appropriate specialty areas are utilized to assist in making determinations of Medical Necessity, as appropriate. All utilization decisions

must be made in a timely manner to accommodate the clinical urgency of the situation, in accordance with federal and state regulatory requirements and NCQA standards.

Requests for authorization not meeting criteria are reviewed by a designated Molina Medical Director or other appropriate clinical professional. Only a licensed physician or pharmacist, doctoral-level clinical psychologist, or certified addiction-medicine specialist (as appropriate) may determine to delay, modify, or deny services to a Member for reasons of Medical Necessity.

Providers can contact Molina's Health Care Services department at **(855) 866-5462** to obtain Molina's UM Criteria.

Medical Necessity
Medically Necessary or **Medical Necessity** means a service that is appropriate, no more restrictive than that used in the state Medicaid Program, including quantitative or non-quantitative treatment limits, as indicated in state statutes and regulations, the state Plan, and other state policies and procedures; also the service meets the standards of good medical practice in the medical community, as determined by the Provider in accordance with contractor's guidelines, policies, or procedures for:

- The diagnosis or treatment of a covered illness or injury.
- The prevention of future disease.
- Assisting in the Enrollee's ability to attain, maintain, or regain functional capacity.
- The opportunity for an Enrollee receiving LTSS to have access to the benefits of community living, to achieve patient-centered goals, and live and work in the setting of the Enrollee's choice.
- An Enrollee to achieve age-appropriate growth and development.

This is to prevent, evaluate, diagnose, or treat an illness, injury, disease, or its symptoms. Those services must be deemed by Molina to be:

1. In accordance with generally accepted standards of medical practice.
2. Clinically appropriate and clinically significant in terms of type, frequency, extent, site, and duration.
3. They are considered effective for the patient's illness, injury, or disease.
4. Not primarily for the convenience of the patient, physician, or other health care Provider.
5. The services must not be costlier than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature. This literature is generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in relevant clinical areas, and any other relevant factors.

The fact that a Provider has prescribed, recommended or approved medical or allied goods or services does not solely make such care, goods, or services Medically Necessary, a Medical Necessity, or a covered service/benefit.

Medical Necessity Review
Molina only reimburses for services that are Medically Necessary. Medical Necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively. To determine Medical Necessity, in conjunction with independent professional medical judgment, Molina uses CMS guidelines, state guidelines, nationally recognized evidence-based guidelines, third-party guidelines, CMS guidelines, state guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks.

Levels of Administrative and Clinical Review
The Molina review process begins with administrative review followed by clinical review if appropriate.

The administrative review includes verifying eligibility, appropriate vendor or Participating Provider, and benefit coverage.
- Verify Member eligibility.
- Requested service is a covered benefit.
- Requested service is within the Provider's scope of practice.
- The requested covered service is directed to the most appropriate contracted specialist, facility, or vendor.

The clinical review includes Medical Necessity and level of care.
- Requested service is not experimental or investigation in nature.
- Servicing Provider can provide the service in a timely manner.
- The receiving specialist(s) and/or hospital is/are provided the required medical information to evaluate a Member's condition.
- Medical Necessity criteria (according to accepted, nationally recognized resources) is met.
- The service is provided at the appropriate level of care in the appropriate facility (e.g., outpatient versus inpatient or at appropriate level of inpatient care).
- Continuity and coordination of care is maintained.
- The PCP is kept appraised of service requests and of the service provided to the Member by other Providers.

All UM requests that may lead to a denial are reviewed by a health care professional at Molina (Medical Director, Pharmacy Director, or appropriately licensed health professional).

Molina's Provider training includes information on the UM processes and authorization requirements.

Clinical Information

Molina requires that copies of clinical information be submitted for documentation in all Medical Necessity determination processes. Clinical information includes, but is not limited to, physician Emergency Department notes, inpatient history/physical exams, discharge summaries, physician progress notes, physician office notes, physician orders, nursing notes, results of laboratory or imaging studies, therapy evaluations, and therapist notes. Molina does not accept clinical summaries, telephone summaries, or inpatient Case Manager criteria reviews as meeting the clinical information requirements unless state or federal regulations allow such documentation to be acceptable.

Prior Authorization

Molina requires Prior Authorization (PA) for specified services, providing the requirement complies with federal or state regulations and the Molina Hospital Agreement or Provider Services Agreement. The list of services that require prior authorization is available in narrative form, along with a more detailed list by Current Procedural Terminology (CPT) and Healthcare Common Procedural Coding System (HCPCS) codes. Molina PA documents are normally updated quarterly but may be updated more frequently as appropriate. They are posted on the Molina website at MolinaHealthcare.com.

Providers are encouraged to use the Molina PA Form provided on the Molina website. If using a different form, the Prior Authorization request **must** include the following information:

- Member demographic information (name, date of birth, Molina ID number).
- Provider demographic information (referring Provider and referred to Provider/facility).
- Member diagnosis and ICD-10 codes.
- Requested service/procedure, including all appropriate CPT and HCPCS codes.
- Location where service will be performed.
- Clinical information that is sufficient to document the Medical Necessity of the requested service including:
    - Pertinent medical history (include treatment, diagnostic tests, examination data).
    - Requested length of stay (for inpatient requests).
    - Rationale for expedited processing.

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by federal and state law) are excluded from the Prior Authorization requirements. Prior Authorization is not a guarantee of payment. Payment is contingent upon Medical Necessity and Member eligibility at the time of service.

Molina makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the Member's clinical situation. The definition of expedited/urgent is when the situation where the standard time frame or decision-making process could seriously jeopardize the life or health of the Enrollee, the health or safety of the Member or others due to the Member's psychological state, or in the opinion of the Provider with knowledge of the Enrollee's medical or behavioral health

condition, would subject the Member to adverse health consequences without the care or treatment that is subject of the request, or could jeopardize the Enrollee's ability to regain maximum function. Supporting documentation is required to justify the expedited request.

For expedited request for authorization, a determination is made as promptly as the Member's health requires and no later than 48 hours after we receive the initial request for service in the event a Provider indicates, or if we determine that a standard authorization decision time frame could jeopardize a Member's life or health. For a standard authorization request, Molina makes the determination and provides notification within four (4) calendar days.

Providers who request Prior Authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina has full-time Medical Directors available to discuss Medical Necessity decisions (peer-to-peer call) with the requesting Provider by contacting the Utilization Management department as indicated on the denial notification to schedule the call. Providers can also submit a request for "reconsideration" in place of a peer-to-peer call if significant information was left out of the original request.

Upon approval, the requestor will receive an authorization number. The number may be provided by telephone or fax. If a request is denied, the requestor and the Member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the Provider by telephone if possible or by fax with confirmation of receipt if telephonic communication fails.

Requesting Prior Authorization
Aside from any provision in the Provider Agreement that requires the Provider to obtain a Prior Authorization directly from Molina, Molina may choose to contract with external vendors to help manage Prior Authorization requests.

For additional information regarding the prior authorization of specialized clinical services, please refer to the Prior Authorization tools located on the MolinaHealthcare.com website:
- Prior Authorization Code Lookup Tool.
- Prior Authorization Code Matrix.
- Prior Authorization Guide.

Provider Portal
Participating Providers are encouraged to use the Provider Portal for Prior Authorization submissions whenever possible. Instructions for how to submit a PA request are available on the Provider Portal. The benefits of submitting your PA request through the Portal are:
- Create and submit Prior Authorization requests.
- Check status of requests.
- Receive notification of change in status of requests.

- Attach medical documentation required for timely medical review and decision-making.

Fax: The Prior Authorization Request Form can be faxed to Molina at **(866) 617-4971**.

Phone: Prior Authorizations can be initiated by contacting Molina's Health Care Services department at **(855) 866-5462**. It may be necessary to submit additional documentation before the authorization can be processed.

Molina has different fax numbers for preauthorization requests for the following specialized clinical services:

- Imaging and special test:
  - Advanced imaging (MRI, CT, PET, selected ultrasounds).
  - Cardiac imaging.
- Radiation therapy.
- Sleep covered services and related equipment.
- Molecular and genomic testing.

Imaging and special tests: **fax (877) 731-7218**. Radiation and specialized services: **fax (844) 251-1451**. Please refer to the Molina Prior Authorization Code Matrix located on the Frequently Used Forms page of the MolinaHealthcare.com website under Authorization Requests.

Emergency Services

Emergency services are inpatient and outpatient health care services that are Covered Services, including transportation needed to evaluate or stabilize an emergency medical condition, and which are furnished by a Provider qualified to furnish Emergency Services.

Emergency Medical Condition or Emergency means a medical condition manifesting itself in acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

A medical screening exam performed by licensed medical personnel in the Emergency Department and subsequent Emergency Services rendered to the Member do not require prior authorization from Molina.

Emergency services are covered on a 24-hour basis without the need for Prior Authorization for all Members experiencing an emergency medical condition.

Molina accomplishes this service by providing a 24-hour Nurse Advice Line for non-business hours. In addition, the 911 information is given to all Members at the onset of any call to the plan.

For Members within our service area, Molina contracts with vendors that provide 24-hour Emergency Services for ambulance and hospitals. An out-of-network emergency hospital stay will be covered until the Member has stabilized sufficiently to transfer to a participating facility. Services provided after stabilization in a non-participating facility are **not** covered, and the Member will be responsible for payment.

Members overutilizing the Emergency Department will be contacted by Molina Care Managers to aid whenever possible and determine the reason for using Emergency Services.

Care Managers will also contact the PCP to ensure that Members are not accessing the Emergency Department because of an inability to be seen by the PCP.

Mobile Crisis Response
As partners in our mission to support and serve children in psychiatric crisis, Molina Healthcare wants to remind you of the following care guidelines to follow:

Mobile Crisis Response Providers:
- Face-to-face screening and assessment should occur within 90 minutes of notification from the CARES line. (HFS has clarified temporarily this may occur via phone/video call due to COVID-19, so that the response time remains the same. The face-to-face requirement will be reinstated when HFS provides an update.)
- Create a crisis safety plan for all individuals who are community stabilized.
- Educate and orient the child and family to the components of the crisis safety plan, and how to review and update.
- Provide the family with a physical copy of the safety plan.
- Share the crisis safety plan with the family, Molina, and any other Providers the family requests, consistent with release of information obtained.

Hospital Providers:
- Administer a physical examination of the child within 24 hours of admission.
- Create a crisis safety plan for all individuals ready for discharge.
- Educate and orient the child and family to the components of the crisis safety plan, and how to review and update.
- Provide the family with a physical copy of the safety plan.
- Share the crisis safety plan with the family, Molina, and any other Providers the family requests, consistent with release of information obtained.
- Communicate admission, pharmaceutical, and discharge information with Primary Care Provider and any other Providers, consistent with family request and release of information obtained to facilitate continuity of care.

Outpatient Behavioral Health Providers, Behavioral Health Centers, and Community Mental Health Centers:
- The IM-CANS must be completed as the standardized individualized assessment and treatment plan prior to billing any non-crisis services within 30 days from the individual’s first outpatient appointment.

- Provide priority access to individuals who have recently had a mobile crisis response assessment and screening required to offer the individual and family access within the following time frames:
  - Fourteen (14) calendar days after an Enrollee's discharge from an inpatient psychiatric hospital setting.
  - Within three calendar days after the date of the crisis event for an Enrollee for whom community-based services were put in place in lieu of psychiatric hospitalization.
- Communicate outcome of the appointment, including the psychiatric resources provided and any change in medication management, with the family, Molina and any other Providers the family requests, consistent with release of information obtained.

Hospital, Psychiatric Residential Treatment Facility (PRTF), Residential, and Crisis Respite Providers:

- Communicate admission, pharmaceutical, and discharge information with Primary Care Provider and any other Providers consistent with family request and release of information obtained to facilitate continuity of care.

Screening Assessment and Support Systems (SASS)
Molina Healthcare of Illinois (Molina) is required to coordinate with pediatric mental health crisis intervention services that are available through the State of Illinois' Mobile Crisis Response (MCR) Program. MCR intervention services are a covered benefit for Members who are younger than 21 years of age.

Molina's Model of Care for its MCR services is patterned after the state program, formerly known as the Screening, Assessment, and Support Systems (SASS) Program. Molina's Model of Care for MCR includes referrals from the CARES Line **(800) 345-9049** and use of the Illinois Medicaid-Crisis Assessment Tool (IM-CAT).

When appropriate, the CARES Line will dispatch Molina's contracted crisis responder to the child's location. The first responder then completes the IM-CAT to determine whether the child can be stabilized in the community. Behavioral health Providers in the Molina network are required to send results of the IM-CAT and assessment tool to Molina within 24 hours of completion of MCR screening for a Molina Member.

IM-CAT results can be submitted to Molina via secure email or fax:

Email: MHILbehavioralhealthreferrals@MolinaHealthcare.com
Fax: (866) 916-3249

Molina is committed to close partnerships with MCR Providers. Members who are the subject of a CARES Line call are assigned to a Molina Case Manager to help support their aftercare. These Case Managers can be a resource for the mobile crisis response team. Molina's partnership with the MCR Program will help Molina monitor prioritization of aftercare counseling and psychiatry for its Members.

Inpatient Management

Elective Inpatient Admissions

Molina requires Prior Authorization for all elective/scheduled inpatient admissions and procedures to any facility. Facilities are required to also notify Molina within 24 hours or by the following business day once the admission has occurred for concurrent review. Elective inpatient admission services performed without Prior Authorization may not be eligible for payment.

Emergent Inpatient Admissions

Molina requires notification of all emergent inpatient admissions within 24 hours of admission or by the following business day. Notification of admission is required to verify eligibility, authorize care (including level of care), and initiate concurrent review and discharge planning. Molina requires that notification includes Member demographic information, facility information, date of admission, and clinical information sufficient to document the Medical Necessity of the admission. Emergent inpatient admission services performed without meeting notification, Medical Necessity requirements, or the failure to include all the required clinical documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient stay.

Inpatient at Time of Termination of Coverage

If a Member's coverage with Molina terminates during a hospital stay, all services received after their termination of eligibility for a hospital with a per diem contract will **not** be covered services. For those Members whose coverage with Molina terminates while at a Diagnosis-Related Group (DRG) hospital, services are generally covered until date of discharge from that hospital.

Inpatient/Concurrent Review

Molina performs concurrent inpatient review to ensure Medical Necessity of ongoing inpatient services, adequate progress of treatment, and development of appropriate discharge plans. Performing these functions requires timely clinical information updates from inpatient facilities. Molina will request updated clinical records from inpatient facilities at regular intervals during a Member's inpatient stay. Molina requires that requested clinical information updates be received by Molina from the inpatient facility within 24 hours of the request.

Failure to provide timely clinical information updates may result in denial of authorization for the remainder of the inpatient admission dependent on the Provider contract terms and agreements.

Molina will authorize hospital care as an inpatient when the clinical record supports the Medical Necessity for the need for continued hospital stay. It is the expectation that observation level of care has been tried in patients that require a period of treatment or assessment, pending a decision regarding the need for additional care, and the observation level of care has failed. Observation level of care does not apply to per diem hospitals. Upon discharge, the Provider must provide Molina with a copy of Member's discharge summary to include demographic information, date of discharge, discharge plan and instructions, and disposition.

Inpatient Status Determinations
Molina's UM staff follow CMS guidelines to determine if the collected clinical information for requested services are "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of malformed body member" by meeting all coverage, coding. and Medical Necessity requirements. Refer to the Medical Necessity Standards section of this manual.

Discharge Planning
The goal of discharge planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission.

UM staff work closely with the hospital discharge planners to determine the most appropriate discharge setting for our Members. The clinical staff review Medical Necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), Skilled Nursing Facility (SNF), and rehabilitative services.

Readmissions
Readmission review is an important part of Molina's Quality Improvement Program to ensure that Molina Members are receiving hospital care that is compliant with nationally recognized guidelines, as well as federal and state regulations.

Molina will conduct readmission reviews for all in-state hospitals when both admissions occur at the same acute inpatient facility within the state regulatory requirement dates. There are two situations for readmissions to the same non-Behavioral Health hospital: (1) readmissions occurring within 24 hours of discharge (same or similar diagnosis); and (2) readmissions occurring within two to 30 days of discharge (same or similar diagnosis, and preventable readmission or complication of the first admission).

When a subsequent admission to the same facility with the same or similar diagnosis occurs within 24 hours of discharge, the hospital will be informed that the readmission will be combined with the initial admission and will be processed as a continued stay.

When a subsequent admission to the same facility occurs within two to 30 days of discharge, and it is determined that the readmission is related to the first admission and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions, and the readmission will **not** be approved for coverage.

A readmission is considered potentially preventable if it is clinically related to the prior admission and includes the following circumstances:
- Premature or inadequate discharge from the same hospital.
- Issues with transition or coordination of care from the initial admission.
- An acute medical complication plausibly related to care that occurred during the initial admission.

Readmissions that are excluded from consideration as preventable readmissions include:

- Planned readmissions associated with major or metastatic malignancies, multiple trauma, and burns.
- Neonatal and obstetrical readmissions.
- Initial admissions with a discharge status of “left against medical advice” because the intended care was not completed.
- Behavioral Health readmissions.
- Transplant-related readmissions.

Readmissions for Substance Use Detoxification and Withdrawal
Molina will conduct readmission reviews for all in-state hospitals when the patient has been admitted twice within 60 days at any hospital (does not need to be the same hospital). Readmission within 60 days for detoxification or withdrawal is **not** covered, per state regulation. See Public Act 097-0689, otherwise known as the SMART Act, for details: illinois.gov/hfs/MedicalProviders/notices/Pages/prn120630f.aspx. The state’s intent with this act was to ensure appropriate and close follow-up for patients with Substance Use Disorder (SUD).

Post-Service Review
Failure to obtain authorization when required will result in denial of payment for those services. The only possible exception for payment resulting from post-service review is if information is received indicating the Provider did not know nor reasonably could have known that the patient was a Molina Member or there was a Molina error; then a Medical Necessity Review will be performed. Decisions, in this circumstance, will be based on medical need, appropriateness of care guidelines defined by UM policies and criteria, regulation, guidance, and evidence-based criteria sets.

Specific federal or state requirements or Provider contracts that prohibit administrative denials supersede this policy.

Affirmative Statement About Incentives
All medical decisions are coordinated and rendered by qualified Molina physicians and licensed clinical staff who are unhindered by fiscal or administrative concerns. Molina and its delegated contractors **do not** use incentive arrangements to reward the restriction of medical care to Members.

Molina requires that all utilization-related decisions regarding Member coverage and/or services are based solely on appropriateness of care and service and existence of coverage. Molina does not reward practitioners or other individuals for issuing denials of coverage or care. Furthermore, Molina does not receive financial incentives or other types of compensation to encourage decisions that result in underutilization.

Open Communication About Treatment
Molina prohibits contracted Providers from limiting Provider or Member communication regarding a Member’s health care. Providers may freely communicate with and act as an advocate for their patients. Molina requires provisions within Provider contracts that prohibit solicitation of Members for alternative coverage arrangements for the primary

purpose of securing financial gain. No communication regarding treatment options may be represented or construed to expand or revise the scope of benefits under a health plan or insurance contract.

Molina and its contracted Providers may not enter into contracts that interfere with any ethical responsibility or legal right of Providers to discuss information with a Member about the Member's health care. This includes, but is not limited to, treatment options, alternative plans, or other coverage arrangements.

Delegated Utilization Management Functions
Molina may delegate UM functions to qualifying medical groups/IPAs and delegated entities. They must have the ability to meet, perform the delegated activities, and maintain specific delegation criteria in compliance with all current Molina policies and regulatory and certification requirements. For more information about delegated UM functions and the oversight of such delegation, please refer to the Delegation Section of this Provider Manual.

Communication and Availability to Members and Providers
HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff at **(855) 866-5462** during normal business hours, Monday through Friday (except for holidays) from 8 a.m. to 5 p.m. Central Time. All staff members identify themselves by providing their first name, job title, and organization.

Molina offers TTY/TDD services for Members who are deaf, hard of hearing, or speech impaired. Language assistance is also always available for Members.

After business hours, Providers can also use fax and the Provider Portal for UM access.

Molina's Nurse Advice Line is available to Members and Providers 24/7 at **(888) 275-8750** and TTY **(866) 735-2929** for English, or **(866) 648-3537** and TTY **(866) 833-4703** for Spanish. The Nurse Advice Line handles urgent and emergent after-hours UM calls. Primary Care Physicians are notified via fax of all Nurse Advice Line encounters.

Out-of-Network Providers and Services
Molina maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process to provide medical care to Molina Members. Molina requires Members to receive medical care within the participating, contracted network of Providers, unless it is for Emergency Services as defined by federal law. If there is a need to go to a non-contracted Provider, all care provided by non-contracted, non-network Providers must be preauthorized by Molina. Non-network Providers may provide Emergency Services for a Member who is temporarily outside the service area without Prior Authorization or as otherwise required by federal or state laws/regulations.

Coordination of Care and Services
Molina HCS staff work with Providers to assist with coordinating referrals, services, and benefits for Members who have been identified for Molina's Integrated Care Management (ICM) Program via assessment or referral, such as self-referral, Provider

referral, etc. In addition, the coordination of care process assists Molina Members, as necessary, in transitioning to other care when benefits end.

Molina staff provide an integrated approach to care needs by assisting Members with identification of resources available to the Member, such as community programs, national support groups, appropriate specialists and facilities, dental and vision services, and identifying best practice or new and innovative approaches to care. Care coordination by Molina staff is done in partnership with Providers, Members, and/or their authorized representative(s) to ensure their efforts are efficient and non-duplicative.

Continuity of Care and Transition of Members
It is Molina's policy to provide Members with advance notice when a Provider they are seeing will no longer be in-network. Members and Providers are encouraged to use this time to transition care to an in-network Provider. The Provider leaving the network shall provide all appropriate information related to course of treatment, medical treatment, etc., to the Provider(s) assuming care. Under certain circumstances, Members may be able to continue treatment with the out-of-network Provider for a given period and provide continued services to Members undergoing a course of treatment by a Provider that has terminated its contractual agreement if the following conditions exist at the time of termination:

- Acute condition or serious chronic condition—Following termination, the terminated Provider will continue to provide covered services to the Member up to 90 days or longer, if necessary, for a safe transfer to another Provider as determined by Molina or its delegated medical group/IPA.
- High-risk second or third trimester pregnancy—The terminated Provider will continue to provide services following termination until postpartum services related to delivery are completed or longer, if necessary, for a safe transfer.

For additional information regarding continuity of care and transition of Members, please contact Molina at **(855) 866-5462**.

Continuity and Coordination of Provider Communication
Molina stresses the importance of timely communication between Providers involved in a Member's care. This is especially critical between specialists, including behavioral health Providers, and the Member's PCP. Information should be shared in such a manner as to facilitate communication of urgent needs or significant findings.

Reporting of Suspected Abuse and/or Neglect
A vulnerable adult is a person who is receiving or may need community-care services by reason of mental or other disability, age or illness, or who is or may be unable to take care of him/herself, or unable to protect him/herself against significant harm or exploitation. When working with children, one may encounter situations suggesting abuse, neglect, and/or unsafe living environments.

Every person who knows or has reasonable suspicion that a child or adult is being abused or neglected must report the matter immediately. Specific professionals mentioned under the law as mandated reporters are:

- Physicians, dentists, interns, residents, or nurses.
- Public or private school employees or childcare givers.
- Psychologists, social workers, family protection workers, or family protection specialists.
- Attorneys, ministers, or law enforcement officers.

If you believe anyone is in immediate danger, **call 911 first**. All critical incidents and cases of suspected abuse and/or neglect should be reported to the Molina Quality team:

Phone: (855) 866-5462
Fax: (855) 556-2074
Email: MHIL-QI@molinahealthcare.com

Suspected abuse and/or neglect should be reported to government agencies as follows:

Child Abuse
For Members who are under the age of 18 and living in the community, reports go to the Department of Children and Family Services 24/7 at **(800) 252-2873** or TTY **(800) 358-5117**. In doing so, this complies with the Abused and Neglected Child Reporting Act 325 ILCS 5/1 et seq. Call if you suspect that a child has been harmed or is at risk of being harmed by abuse or neglect. If you believe a child is in immediate danger, **call 911 first**.

Adult Abuse
For Members who are age 18 and older and living in the community, reports go to the Illinois Department on Aging via the Adult Protective Services Hotline number at **(866) 800-1409** or TTY **(800) 206-1327**. This complies with the Adult Protective Services Act 320 ILCS 20/1-1 et seq., the Abuse of Adults with Disabilities Intervention Act 20 ILCS 2435/1 et seq., and the Elder Abuse and Neglect Act 320 ILCS 20/1 et seq.

For Members residing in Supportive Living Facilities (SLF), reports go to the Department of Healthcare and Family Services' SLF Complaint Hotline at **(800) 226-0768**. This complies with the 89 Ill. Adm. Code, Section 146.305 for Reporting of Suspected Abuse, Neglect, and Financial Exploitation in Specialized Health Care Delivery Systems through the Department of Healthcare and Family Services Medical Programs.

For Members aged 18 to 59 receiving mental health or Developmental Disability services in DHS operated, licensed, certified, or funded programs, use the Illinois Department of Human Services Office of the Inspector General Hotline at **(800) 368-1463** (voice and TTY). In doing so, this complies with the Department of Human Services Act 20 ILCS 1305/1-1 et seq.

For Members who are residing in Nursing Facilities, reports go to the Department of Public Health's Nursing Home Complaint Hotline at **(800) 252-4343**. This complies with the Abused and Neglected Long Term Care Facility Residents Reporting Act 210 ILCS 30/1 et seq.

Molina's HCS team will work with PCPs, medical groups/IPAs, and other delegated entities who are obligated to communicate with each other when there is a concern that

a Member is being abused. Final actions are taken by the PCP/Medical Group/IPA, other delegated entities, or other clinical personnel. Under state and federal law, a person participating in good faith in making a report or testifying about alleged abuse, neglect, abandonment, financial exploitation, or self-neglect of a vulnerable adult in a judicial or administrative proceeding may be immune from liability resulting from the report or testimony.

Molina will follow up with Members that are reported to have been abused, exploited, or neglected to ensure appropriate measures were taken and to follow up on safety issues. Molina will track, analyze, and report aggregate information regarding abuse reporting to the Health Care Services Committee and the proper state agency.

PCP Responsibilities in Care Management Referrals
The Member's PCP is the primary leader of the health team involved in the coordination and direction of services for the Member. The Case Manager provides the PCP with the Member's Integrated Care Program (ICP), Interdisciplinary Care Team (ICT) updates, and information regarding the Member's progress through the ICP when requested by the PCP. The PCP is responsible for the provision of preventive services and for the primary medical care of Members.

Care Manager Responsibilities
The Care Manager collaborates with the Member and any additional participants as directed by the Member to develop an ICP that includes recommended interventions from Member's ICT, as applicable. ICP interventions include the appropriate information to address medical and psychosocial needs and/or barriers to accessing care, care coordination to address Member's health care goals, health education to support self-management goals, and a statement of expected outcomes. Jointly, the Care Manager and the Member/authorized representative(s) are responsible for implementing the plan of care. Additionally, the Care Manager:

- Assesses the Member to determine if the Members' needs warrant care management.
- Monitors and communicates the progress of the implemented ICP to the Members' ICT, as Member needs warrant.
- Serves as a coordinator and resource to the Member, their representative(s), and ICT participants throughout the implementation of the ICP, and revises the plan as suggested and needed.
- Coordinates appropriate education and encourages the Member's role in self-management.
- Monitors progress toward the Member's achievement of ICP goals to determine an appropriate time for the Member's graduation from the ICM Program.

Health Management
The tools and services described here are educational support for Molina Members and may be changed at any time as necessary to meet the needs of Molina Members.

Health Education/Disease Management
Molina offers programs to help our Members and their families manage various health conditions. The programs include telephonic outreach from our clinical staff and health educators, along with access to educational materials. You can refer Members who may benefit from the additional education and support Molina offers. Members can request to be enrolled or disenrolled in these programs at any time. Our programs include:

- Asthma management.
- Diabetes management.
- High blood pressure management.
- Heart failure.
- Chronic Obstructive Pulmonary Disease (COPD) management.
- Depression management.
- Obesity.
- Weight management.
- Smoking cessation.
- Organ transplant.
- Serious and Persistent Mental Illness (SPMI) and Substance Use Disorder (SUD).
- Maternity screening and high-risk obstetrics.

For smoking cessation and weight management, call **(866) 472-9483** (TTY/TDD at 711). For information about the other programs, call **(866) 891-2320** (TTY/TDD at 711).

Pregnancy Notification Process
The PCP shall submit to Molina the Pregnancy Notification Report Form (available at MolinaHealthcare.com) within one (1) working day of the first prenatal visit and/or positive pregnancy test.

The information may be phoned, faxed, or emailed to Molina:

Phone: (855) 687-7861
Fax: (844) 479-5341
Email: Quality-HealthCampaigns@MolinaHealthCare.com

For more info about our programs, please call Provider Network Management at **(855) 866-5462** (TTY/TDD 711). Visit MolinaHealthcare.com.

Member Newsletters
Member Newsletters are posted on the MolinaHealthcare.com website at least once per year. The articles are about topics requested by Members. The tips are intended to help Members stay healthy.

Member Health Education Materials
Members can access our easy-to-read materials about nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, diabetes, and other topics. To get these materials, Members are directed to ask their doctor or visit the Members section of our website.

Program Eligibility Criteria and Referral Source
Health Management (HM) Programs are designed for Molina Members with a confirmed diagnosis. Identified Members will receive targeted outreach, such as educational newsletters, telephonic outreach, or other materials to access information on their condition. Members can contact Molina Member Services at any time and request to be removed from the program.

Members may be identified for or referred to HM Programs from multiple pathways which may include the following:

- Pharmacy claims data for all classifications of medications.
- Encounter Data or paid claims with a relevant CMS-accepted diagnosis or procedure code.
- Member Services "welcome" calls made by staff to new Member households and incoming Member calls have the potential to identify eligible program participants. Eligible Members are referred to the program registry.
- Member assessment calls made by staff for the initial Health Risk Assessments (HRA) for newly enrolled Members.
- External referrals from Providers, caregivers, or community-based organizations.
- Internal referrals from the Nurse Advice Line, Medication Management, or Utilization Management.
- Member self-referral due to general plan promotion of program through Member newsletter or other Member communications.

Provider Participation
Contracted Providers are notified, as appropriate, when the Member is enrolled in a Health Management Program. Provider resources and services may include:

- Annual Provider feedback letters containing a list of patients identified with the relevant disease.
- Clinical resources, such as patient assessment forms and diagnostic tools.
- Patient education resources.
- Provider Newsletters promoting the Health Management Programs, including outcomes of the programs and how to enroll patients.
- Clinical Practice Guidelines.
- Preventive Health Guidelines.

Additional information on Health Management Programs is available from the Molina Health Care Services department toll free at **(855) 866-5462**.

Members may qualify for Molina's ICM Program based on confirmed diagnosis or specified criteria. The comprehensive programs are available for all Members that meet the criteria for services.

Care Management (CM)
Molina provides a comprehensive ICM Program to all Members who meet the criteria for services. The ICM Program focuses on coordinating the care, services, and resources needed by Members throughout the continuum of care. Molina adheres to Case

Management Society of America Standards of Practice Guidelines in its execution of the program.

The Molina Care Managers may be licensed professionals and are educated, trained. and experienced in Molina's ICM Program. The ICM Program is based on a Member advocacy philosophy, designed and administered to assure the Member value-added coordination of health care and services to increase continuity and efficiency, and to produce optimal outcomes. The ICM Program is individualized to accommodate a Member's needs with collaboration and input from the Member's PCP. The Molina Care Manager will assess the Member upon engagement after identification for ICM enrollment, assist with arrangement of individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina Care Manager is responsible for assessing the Member's appropriateness for the ICM Program and for notifying the PCP of ICM Program enrollment, as well as facilitating and assisting with the development of the Members' ICP.

Referral to Care Management
Members with high-risk medical conditions and/or other care needs may be referred by their PCP or specialty care Provider to the ICM Program. The Care Manager works collaboratively with the Member and all participants of the ICT when warranted, including the PCP and specialty Providers, such as discharge planners, ancillary Providers, the local health department, or other community-based resources when identified. The referral source should be prepared to provide the Care Manager with demographic, health care, and social data about the Member being referred.

Members with the following conditions may qualify for Care Management and should be referred to the Molina ICM Program for evaluation:

- High-risk pregnancy, including Members with a history of a previous preterm delivery.
- Catastrophic or end-stage medical conditions (e.g., neoplasm, organ/tissue transplants, end-stage renal disease).
- Comorbid chronic illnesses (e.g., asthma, diabetes, COPD, CHF, etc.).
- Members receiving seven or more medications.
- Preterm births.
- High-tech home care requiring more than two weeks of treatment.
- Member accessing Emergency Department Services inappropriately.
- Children with special health care needs.

Referrals to the ICM Program may be made by contacting Molina at:

Phone: (855) 687-7861
Email: CMEscalationIL@MolinaHealthcare.com

8. Pharmacy

Prescription drug therapy is an integral component of your patient's comprehensive treatment program. Molina's goal is to provide our Members with high-quality, cost-effective drug therapy. Molina works with our Providers and Pharmacists to ensure that medications used to treat a variety of conditions and diseases are offered. Molina covers prescription and certain over-the-counter (OTC) drugs.

Pharmacy and Therapeutics Committee
Molina Healthcare follows the Preferred Drug List (PDL) provided by Illinois Department of Healthcare and Family Services (HFS). HFS makes prior approval and PDL decisions in consultation with the Drugs and Therapeutics Advisory Board (D and T Advisory Board). The D and T Advisory Board is comprised of practicing clinicians representing various specialties who actively participate in the Illinois Medicaid Program. The Advisory Board makes recommendations based upon evidence-based clinical factors including safety, effectiveness, and outcomes.

Molina Healthcare also utilizes its National Pharmacy and Therapeutics Committee (P&T), which meets quarterly to review and recommend medications for formulary consideration. The P&T is organized to assist Molina with managing pharmacy resources and to improve the overall satisfaction of Molina Members and Providers. It seeks to ensure that Molina Members receive appropriate and necessary medications. An annual pharmacy work plan governs all the activities of the committee. The committee's voting membership consists of external physicians and pharmacists from various clinical specialties.

Pharmacy Network
Members must use their Molina ID card to get prescriptions filled. Additional information regarding the pharmacy benefits, limitations, and network pharmacies is available by visiting MolinaHealthcare.com or calling Molina at **(855) 866-5462**.

Drug Formulary
The pharmacy program does **not** cover all medications. Some medications require Prior Authorization (PA) or have limitations on age, dosage, and/or quantities. For a complete list of covered medications, please visit the Formulary page at MolinaHealthcare.com.

Information on procedures to obtain these medications is described within this document and also on the Formulary page at MolinaHealthcare.com.

Formulary Medications
In some cases, Members may only be able to receive certain quantities of medication. Information on limits are included and can be found in the formulary page of the website.

Formulary medications with PA may require the use of first-line medications before they are approved.

Quantity Limitations
Quantity limitations have been placed on certain medications to ensure safe and appropriate use of the medication.

Age Limits
Some medications may have age limits. Age limits align with current U.S. Food and Drug Administration (FDA) alerts for the appropriate use of pharmaceuticals.

Step Therapy
Plan restrictions for certain formulary drugs may require that other drugs be tried first. The formulary designates drugs that may process under the pharmacy benefit without Prior Authorization if the Member's pharmacy fill history with Molina shows other drugs have been tried for certain lengths of time. If the Member has trialed certain drugs prior to joining Molina, documentation in the clinical record can serve to satisfy requirements when submitted to Molina for review. Drug samples from Providers or manufacturers are **not** considered as meeting step therapy requirements or as justification for exception requests.

Non-Formulary Medications
Non-formulary medications may be considered for exception when formulary medications are not appropriate or have proven ineffective for a particular Member. Requests for formulary exceptions should be submitted using a Pharmacy PA form, available on the Formulary page of MolinaHealthcare.com. Clinical evidence must be provided and is taken into account when evaluating the request to determine Medical Necessity. The use of manufacturer's samples of non-formulary or "Prior Authorization Required" medications does **not** override formulary requirements.

Generic Substitution
Generic drugs should be dispensed when available. If the use of a particular brand name becomes Medically Necessary as determined by the Provider, PA must be obtained through the standard PA process.

New-to-Market Drugs
Newly approved drug products will not normally be placed on the formulary during their first six months on the market. During this period, access to these medications will be considered through the PA process.

Medications Not Covered
Medications not covered by Medicaid are excluded from coverage. For example, drugs used in the treatment of fertility, sexual dysfunction, or those used for cosmetic purposes are **not** part of the benefit.

Submitting a Prior Authorization Request
Molina will only process **completed** PA request forms; the following information **must** be included for the Pharmacy PA form to be considered complete:

- Member first name, last name, date of birth, and identification number.
- Prescriber first name, last name, NPI, phone number, and fax number.
- Drug name, strength, quantity, and directions of use.

- Diagnosis.

Molina's decisions are based upon the information included with the PA request. Clinical notes are recommended. If clinical information and/or medical justification is missing, Molina will either fax or call your office to request clinical information be sent in to complete the review. To avoid delays in decisions, be sure to complete the Pharmacy PA form in its entirety, including medical justification and/or supporting clinical notes.

Fax a completed Medication PA Request form to Molina at **(855) 365-8112**. A blank Pharmacy PA Request form may be obtained by accessing MolinaHealthcare.com or by calling **(855) 866-5462**.

Member and Provider "Patient Safety Notifications"
Molina has a process to notify Members and Providers regarding a variety of safety issues, which include voluntary recalls, FDA required recalls, and drug withdrawals for patient safety reasons. This is also a requirement as an NCQA-accredited organization.

Specialty Pharmaceuticals, Injectable and Infusion Services
Many specialty medications are covered by Molina through the pharmacy benefit using National Drug Codes (NDC) for billing and specialty pharmacy for dispensing to the Member or Provider. Some of these same medications maybe covered through the medical benefit using Healthcare Common Procedure Coding System (HCPCS) via paper or electronic medical claim submission.

Molina, during the Utilization Management review process, will review the requested medication for the most cost-effective, yet clinically appropriate benefit (medical or pharmacy) of select specialty medications. All reviewers will first identify Member eligibility, any federal or state regulatory requirements, and the Member-specific benefit plan coverage prior to determination of benefit processing.

If it is determined to be a pharmacy benefit, Molina's pharmacy vendor will coordinate with Molina and ship the prescription directly to your office or the Member's home. All packages are individually marked for each Member, and refrigerated drugs are shipped in insulated packages with frozen gel packs. The service also offers the additional convenience of enclosing needed ancillary supplies (needles, syringes, and alcohol swabs) with each prescription at no charge. Please contact your Provider Network Manager with any further questions about the program.

Newly FDA-approved medications are considered non-formulary and subject to non-formulary policies and other non-formulary utilization criteria until a coverage decision is rendered by the Molina Pharmacy and Therapeutics Committee.

"Buy-and-bill" drugs are pharmaceuticals that a Provider purchases and administers, and for which the Provider submits a claim to Molina for reimbursement.

Pain Safety Initiative (PSI) Resources
Safe and appropriate opioid prescribing and utilization is a priority for all of us in health care. Molina requires Providers to adhere to Molina's drug formularies and prescription

policies, which are designed to prevent abuse or misuse of high-risk chronic pain medication. Providers are expected to offer additional education and support to Members regarding opioid and pain safety as needed.

Molina is dedicated to ensuring that Providers are equipped with additional resources, which can be found on the Molina Provider website. Providers may access additional opioid-safety and Substance Use Disorder resources at MolinaHealthcare.com under the Health Resources tab. Please consult with your Provider Network Manager or reference the medication formulary for more information on Molina's Pain Safety Initiatives.

9. Provider Responsibilities

Nondiscrimination of Health Care Service Delivery
Molina complies with the guidance set forth in the final rule for Section 1557 of the Affordable Care Act (ACA), which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina Medicaid website home pages. All Providers who join the Molina Provider Network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR).

For more information about Non-discrimination of Health Care Service Delivery, please see the Cultural Competency and Linguistic Services section of this Provider Manual.

Section 1557 Investigations
All Molina Providers shall disclose all investigations conducted pursuant to Section 1557 of the Patient Protection and Affordable Care Act to Molina's Civil Rights Coordinator.

Molina Healthcare
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802
Toll Free: (866) 606-3889
TTY/TDD: 711
Online: MolinaHealthcare.AlertLine.com
Email: civil.rights@MolinaHealthcare.com

Facilities, Equipment, and Personnel
The Provider's facilities, equipment, personnel, and administrative services must be at a level and quality necessary to perform duties and responsibilities to meet all applicable legal requirements including the accessibility requirements of the Americans with Disabilities Act (ADA).

Cooperation Between Providers
Molina encourages network Providers and subcontractors to cooperate and communicate with other service Providers who serve Enrollees. Such other service Providers may include WIC programs, Head Start programs, Early Intervention programs, day care programs, and school systems among others. Such cooperation may include performing annual physical examinations for school and the sharing of information (with the consent of the Enrollee, parent, or legal guardian if the Enrollee is underage). Annual health examinations for school include an age-appropriate developmental screening, and an age-appropriate social and emotional screening, as required by Public Act 99-927.

Provider Data Accuracy and Validation
It is important for Providers to ensure Molina has accurate practice and business information. Accurate information allows us to better support and serve our Members and our Provider Network.

Maintaining an accurate and current Provider Directory is a state and federal regulatory requirement, as well as an NCQA required element. Invalid information can negatively impact Member access to care, Member/PCP assignments and referrals. Additionally, current information is critical for timely and accurate claims processing.

Providers must validate the Provider Online Directory (POD) information at least quarterly for correctness and completeness. Providers must notify Molina in writing (some changes can be made online) at least 30 days in advance of changes such as, but not limited to:

- Change in office location(s), office hours, phone, fax, or email.
- Addition or closure of office location(s).
- Addition or termination of a Provider (within an existing clinic/practice).
- Change in practice name, Tax ID, and/or National Provider Identifier (NPI).
- Opening or closing your practice to new patients (PCPs only).
- Any other information that may impact Member access to care.

Please visit our Provider Online Directory at providersearch.MolinaHealthcare.com to validate and correct most of your information. A convenient Provider web form can be found on the POD and on the Provider Portal at provider.MolinaHealthcare.com. You can also notify your Provider Network Manager if your information needs to be updated or corrected.

Molina is required to audit and validate our Provider Network data and Provider Directories on a routine basis. As part of our validation efforts, we may reach out to our network of Providers through various methods, such as letters, phone campaigns, face-to-face contact, fax and fax-back verification, etc. Molina also may use a vendor to conduct routine outreach to validate data that impacts the Provider Directory or otherwise impacts its membership or ability to coordinate Member care. Providers are required to provide timely responses to such communications.

National Plan and Provider Enumeration System (NPPES) Data Verification
CMS recommends that Providers routinely verify and attest to the accuracy of their National Plan and Provider Enumeration System (NPPES) data.

NPPES allows Providers to attest to the accuracy of their data. If the data is correct, the Provider can attest, and NPPES will reflect the attestation date. If the information is not correct, the Provider is able to request a change to the record and attest to the changed data, resulting in an updated certification date.

Molina supports the CMS recommendations around NPPES data verification and encourages our Provider Network to verify Provider data via nppes.cms.hhs.gov. Additional information regarding the use of NPPES is available in the Frequently Asked

Questions (FAQs) document published at the following link: cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.

Molina Electronic Solutions Requirements
Molina requires Providers to utilize electronic solutions and tools whenever possible.

Molina requires all contracted Providers to participate in and comply with Molina's electronic solution requirements, which include, but are not limited to, electronic submission of Prior Authorization requests, Prior Authorization status inquiries, health plan access to Electronic Medical Records (EMR), electronic claims submission, Electronic Fund Transfers (EFT), electronic remittance advice (ERA), electronic claims appeal, and registration for and use of the Provider Portal.

Electronic claims include claims submitted via a clearinghouse using the EDI process and claims submitted through the Provider Portal.

Any Provider entering the network as a Contracted Provider will be required to comply with Molina's Electronic Solution Policy by enrolling for EFT/ERA payments and registering for the Provider Portal within 30 days of entering the Molina network.

Molina is committed to complying with all HIPAA Transactions, Code Sets, and Identifiers (TCI) standards. Providers must comply with all HIPAA requirements when using electronic solutions with Molina. Providers must obtain a National Provider Identifier (NPI) and use their NPI in HIPAA Transactions, including claims submitted to Molina. Providers may obtain additional information by visiting Molina's HIPAA Resource Center located on our website at MolinaHealthcare.com.

Electronic Solutions/Tools Available to Providers
Electronic tools/solutions available to Molina Providers include:
- Electronic claims submission options.
- Electronic payment: EFT with ERA.
- Provider Portal.

Electronic Claims Submission Requirement
Molina strongly encourages Participating Providers to submit claims electronically whenever possible. Electronic claims submission provides significant benefits to the Provider such as:
- Promoting HIPAA compliance.
- Helping reduce operational costs associated with paper claims (printing, postage, etc.).
- Increasing accuracy of data and efficient information delivery.
- Reducing claim processing delays as errors can be corrected and resubmitted electronically.
- Eliminating mailing time, enabling claims to reach Molina faster.

Molina offers the following electronic claims submission options:

- Submit claims directly into the Provider Portal. Log into the Portal or contact your Provider Network Manager for registration and claim submission guidance.
- Submit claims to Molina through your EDI clearinghouse using **Payer ID 20934**; refer to our website MolinaHealthcare.com for additional information.

While both options are embraced by Molina, submitting claims via the Provider Portal (available to all Providers at no cost) offers several additional claims processing benefits beyond the possible cost savings achieved from the reduction of paper claims.

Provider Portal claims submission benefits include:
- Adding attachments to claims.
- Submitting corrected claims.
- Easily and quickly voiding claims.
- Checking claims status.
- Receiving timely notification of a change in status for a particular claim.
- Saving incomplete/unsubmitted claims.
- Creating/managing claim templates.

For more information on EDI claims submission, see the Claims and Compensation section of this Provider Manual.

Electronic Payment (EFT/ERA) Requirement
Participating Providers are required to enroll in Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services give Providers the ability to reduce paperwork, utilize searchable ERAs, and receive payment and ERA access faster than the paper check and Remittance Advice (RA) processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery processes.

Below is the link to register with Change Healthcare ProviderNet to receive EFTs/ERAs. Additional instructions about how to register are available under the EDI/ERA/EFT tab on Molina's website MolinaHealthcare.com.

Any questions during this process should be directed to Change Healthcare Provider Services at wco.provider.registration at changehealthcare.com or **(877) 389-1160**.

Availity Provider Portal
Providers are required to register for and utilize the Availity Provider Portal. The Portal is an easy-to-use, online tool available to all our Providers at **no cost**. The Provider Portal offers the following functionality:
- Verify and print Member eligibility.
- View benefits, covered services, and Member health records.
- View roster of assigned Molina Members for PCP(s).
- Claims Functions:
  - Professional and institutional claims (individual or multiple claims).

    - Receive notification of claims status change.
    - Correct claims.
    - Void claims.
    - Add attachments to previously submitted claims.
    - Check claims status.
    - Export claims reports.
    - Create and manage claim templates.
    - Open saved claims.
- Prior Authorizations/Service Requests:
    - Create and submit Prior Authorization/Service Requests.
    - Check status of Authorization/Service Requests.
    - Receive notification of change in status of Authorization/Service Requests.
    - Create Authorization/Service Request Templates.
- View HEDIS® Scores and compare to national benchmarks.
- Appeals:
    - Create and submit a claim appeal.
    - Add appeal attachments to appeal.
    - Receive email confirmation.

Provider Portal

Providers and third-party billers can use the no-cost Provider Portal to perform many functions online without the need to call or fax Molina. Registration can be performed online and, once completed, the easy-to-use tool offers the following features:

- Verify Member eligibility, covered services, and view HEDIS® needed services (gaps)
- Claims:
    - Submit professional (CMS-1500) and institutional (UB-04) claims with attached files.
    - Correct/void claims.
    - Add attachments to previously submitted claims.
    - Check claims status.
    - Create and manage claim templates.
    - Create and submit a claim appeal with attached files.
- Prior Authorizations/Service Requests:
    - Create and submit Prior Authorization/Service Requests.
    - Check status of Authorization/Service Requests.
- View HEDIS® Scores and compare to national benchmarks.
- View a roster of assigned Molina Members for PCP(s).
- Download forms and documents.
- Send/receive secure messages to/from Molina.

Balance Billing

Non-contracted Providers and Providers that are contracted with Molina **cannot** bill the Member for any Covered Services. The Provider is responsible for verifying eligibility and obtaining approval for those services that require Prior Authorization.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Molina to the Provider. Balance billing a Molina Member for Covered Services is prohibited, other than for the Member's applicable copayment, coinsurance, and deductible amounts.

Member Rights and Responsibilities
Providers are required to comply with the Member Rights and Responsibilities as outlined in Molina's Member materials (such as Member Handbooks).

For additional information, please refer to the Member Rights and Responsibilities section of this Provider Manual.

Member Information and Marketing
Any written informational or marketing materials directed to Molina Members must be developed and distributed in a manner compliant with all state and federal laws and regulations, and approved by Molina prior to use.

Please contact your Provider Network Manager for information and review of proposed materials.

Member Eligibility Verification
Possession of a Molina ID card does not guarantee Member eligibility or coverage. Providers should verify eligibility of Molina Members prior to rendering services. Payment for services rendered is based on enrollment and benefit eligibility. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

For additional information please refer to the Enrollment, Eligibility, and Disenrollment section of this Provider Manual.

Member Cost-Share
Under no circumstance will Members be liable for any amount owed by Molina to the Provider. Balance billing Molina Members for services covered by Molina is prohibited. This includes asking Members to pay the difference between the discounted and negotiated fees and the Provider's usual and customary fees. In addition, Providers are responsible for verifying eligibility and obtaining approval for services that require Prior Authorization.

Providers should verify the Molina Member's cost-share status prior to requiring the Member to pay copay, coinsurance, deductible, or other cost-share that may be applicable to the Member's specific benefit plan. Some plans have a total maximum cost-share that frees the Member from any further out-of-pocket charges once reached (during that calendar year).

Health Care Services (Utilization Management and Care Management)
Providers are required to participate in and comply with Molina's Utilization Management and Care Management Programs, including all policies and procedures

regarding Molina's facility admission, Prior Authorization, Medical Necessity review determination, and Interdisciplinary Care Team (ICT) procedures. Providers will also cooperate with Molina in audits to identify, confirm, and/or assess utilization levels of covered services.

For additional information, please refer to the Health Care Services section of this Provider Manual.

In-Office Laboratory Tests
Molina's policies allow only certain lab tests to be performed in a Provider's office regardless of the line of business. All other lab testing must be referred to an In-Network Laboratory Provider that is a certified, full service laboratory, offering a comprehensive test menu that includes routine, complex, drug, genetic testing and pathology. A list of those lab services that are allowed to be performed in the Provider's office is found on the Molina website at MolinaHealthcare.com.

Additional information regarding in-network laboratory Providers and in-network laboratory Provider patient service centers is found on the laboratory Providers' respective websites at QuestDiagnostics.com and LabCorp.com.

Specimen collection is allowed in a Provider's office and shall be compensated in accordance with your agreement with Molina and applicable state and federal billing and payment rules and regulations.

Claims for tests performed in the Provider's office, but not on Molina's list of allowed in-office laboratory tests, will be denied.

Referrals
Network Providers should have and maintain admitting privileges and, as appropriate, delivery privileges. In lieu of these privileges, the Provider should have a written referral agreement with a network Provider who has such privileges at a network hospital. The agreement must provide for transfer of medical records and coordination of care between physicians.

A referral is necessary when a Provider determines Medically Necessary services are beyond the scope of the PCP's practice. or it is necessary to consult or obtain services from other in-network specialty health professionals unless the situation is one involving the delivery of Emergency Services. Information is to be exchanged between the PCP and specialist to coordinate care of the patient to ensure continuity of care. Providers must document referrals in the patient's medical record. Documentation needs to include the specialty, services requested, and diagnosis for which the referral is being made.

Providers should direct Molina Members to health professionals, hospitals, laboratories, and other facilities and Providers that are contracted and credentialed (if applicable) with Molina. In the case of Emergency Services, Providers may direct Members to an appropriate service including, but not limited to, primary care, urgent care, and Emergency Services. There may be circumstances in which referrals may require an

out-of-network Provider. Prior Authorization will be required from Molina, except in the case of Emergency Services.

For additional information, please refer to the Health Care Services section of this Provider Manual.

PCPs are able to refer a Member to an in-network specialist for consultation and treatment without a Prior Authorization.

Treatment Alternatives and Communication with Members
Molina endorses open Provider/Member communication regarding appropriate treatment alternatives and any follow-up care. Molina promotes open discussion between Provider and Members regarding medically necessary or appropriate patient care, regardless of covered benefits limitations. Providers are free to communicate any and all treatment options to Members regardless of benefit coverage limitations. Providers are also encouraged to promote and facilitate training in self-care and other measures Members may take to promote their own health.

Maternal Care
Molina requires that all contracted hospitals and birthing centers have policies in place that safely reduce C-sections and Early Elective Delivery (EED). Molina will enable Members to receive timely and evidence-based postpartum care. At a minimum, Molina shall provide and document the following services:

Postpartum visits, in accordance with the HFS' approved schedule, to assess and provide education on areas such as perineum care, breastfeeding/feeding practices, nutrition, exercise, immunization, sexual activity, effective family planning, pregnancy intervals, physical activity, SIDS, the importance of ongoing well-woman care, and referral to parenting classes, maternity education tools, platforms and materials, and WIC.

Pharmacy Program
Providers are required to adhere to Molina's drug formularies and prescription policies. For additional information, please refer to the Pharmacy section of this Provider Manual.

Participation in Quality Programs
Providers are expected to participate in Molina's Quality Programs and collaborate with Molina in conducting peer review and audits of care rendered by Providers. Such participation includes, but is not limited to:
- Access to care standards.
- Site and medical record-keeping practice reviews as applicable.
- Delivery of patient care information.

For additional information, please refer to the Quality section of this Provider Manual.

Compliance
Providers must comply with all state and federal laws and regulations related to the care and management of Molina Members.

Confidentiality of Member Health Information and HIPAA Transactions
Molina requires that Providers respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable laws and regulations regarding the privacy of patient and Member PHI. For additional information, please refer to the Compliance section of this Provider Manual.

Participation in Grievance and Appeals Programs
Providers are required to participate in Molina's Grievance Program and cooperate with Molina in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries. If a Member has a complaint regarding a Provider, the Provider will participate in the investigation of the grievance. If a Member submits an appeal, the Provider will participate by providing medical records or statements if needed. This includes the maintenance and retention of Member records for a period of not less than ten (10) years and retained further if the records are under review or audit until such time that the review or audit is complete.

For additional information, please refer to the Appeals and Grievances section of this Provider Manual.

Participation in Credentialing
Providers are required to participate in Molina's credentialing and re-credentialing process and will satisfy, throughout the term of their contract, all credentialing and re-credentialing criteria established by Molina and applicable accreditation, state and federal requirements. This includes providing prompt responses to Molina's requests for information related to the credentialing or re-credentialing process.

Providers must notify Molina no less than 30 days in advance when they relocate or open an additional office.

More information about Molina's Credentialing Program, including policies and procedures, is available in the Credentialing and Recredentialing section of this Provider Manual.

Delegation
Delegated entities must comply with the terms and conditions outlined in Molina's Delegation Policies and Delegated Services Addendum. Please see the Delegation section of this Provider Manual for more information about Molina's delegation requirements and delegation oversight.

10. Quality

Maintaining Quality Improvement Processes and Programs
Molina works with Members and Providers to maintain a comprehensive Quality Improvement Program. You can contact the Molina Quality department toll free at **(855) 866-5462** or fax **(855) 556-2074**.

The address for mail requests is:

Molina Healthcare of Illinois, Inc.
Quality Department
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523

This Provider Manual contains excerpts from the Molina Quality Improvement Program. For a complete copy of Molina's Quality Improvement Program, you can contact your Provider Network Manager or call the telephone number above to receive a written copy.

Molina has established a Quality Improvement Program that complies with regulatory requirements and accreditation standards. The Quality Improvement Program provides structure and outlines specific activities designed to improve the care, service, and health of our Members. In our quality program description, we describe our program governance, scope, goals, measurable objectives, structure, and responsibilities.

Molina does not delegate quality improvement activities to medical groups/IPAs. However, Molina requires contracted medical groups/IPAs to comply with the following core elements and standards of care. Molina medical groups/IPAs must:

- Have a Quality Improvement Program in place.
- Comply with and participate in Molina's Quality Improvement Program, including reporting of Access and Availability survey and activity results and provision of medical records as part of the HEDIS® review process and during potential Quality of Care and/or Critical Incident investigations.
- Cooperate with Molina's quality improvement activities that are designed to improve quality of care and services, as well as Member experience.
- Allow Molina to collect, use, and evaluate data related to Provider performance for quality improvement activities, including but not limited to focus areas (such as clinical care), care coordination and management, service, and access and availability.
- Allow access to Molina quality personnel for site and medical record review processes.

Patient Safety Program
Molina's Patient Safety Program identifies appropriate safety projects and error avoidance for Molina Members in collaboration with their PCPs. Molina continues to support safe personal health practices for our Members through our Safety Program, Pharmaceutical Management, and Case Management/Disease Management Programs and education. Molina monitors nationally recognized quality index ratings for facilities,

including adverse events and hospital-acquired conditions, as part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA), Health and Human Services (HHS), to identify areas that have the potential for improving health care quality to reduce the incidence of events.

Quality of Care
Molina has established a systematic process to identify, investigate, review, and report any quality of care, adverse event/never event, critical incident (as applicable), and/or service issues affecting Member care. Molina will research, resolve, track, and trend issues. Confirmed adverse events/never events are reportable when related to an error in medical care that is clearly identifiable, preventable, and/or is found to have caused serious injury or death to a patient. Some examples of Never Events include:

- Surgery on the wrong body part.
- Surgery on the wrong patient.
- Wrong surgery on a patient.

Molina is **not** required to pay for inpatient care related to "Never Events."

Medical Records
Molina requires that medical records are maintained in a manner that is current, detailed, and organized to ensure that care rendered to Members is consistently documented and that necessary information is readily available in the medical record. All entries will be indelibly added to the Member's record. PCPs should maintain the following medical record components, that include but are not limited to:

- Medical record confidentiality and release of medical records within medical and behavioral health care records.
- Medical record content and documentation standards, including preventive health care.
- Storage maintenance and disposal processes.
- Process for archiving medical records and implementing improvement activities.

Medical Record-Keeping Practices
Below is a list of the minimum items that are necessary in the maintenance of the Molina Member's medical records:

- Each patient has a separate record.
- Medical records are stored away from patient areas and preferably locked.
- Medical records are available at each visit, and archived records are available within 24 hours.
- If hardcopy, pages are securely attached in the medical record, and records are organized by dividers or color-coded when thickness of the record dictates.
- If electronic, all those with access have individual passwords.
- Record-keeping is monitored for quality and HIPAA compliance.
- Storage maintenance for the determined timeline and disposal per record management processes.
- Process for archiving medical records and implementing improvement activities.
- Medical records are kept confidential, and there is a process for release of medical records including behavioral health care records.

Content

Providers must remain consistent in their practices with Molina's medical record documentation guidelines. Medical records are maintained and should include the following information:

- Each page in the record contains the patient's name or ID number.
- Member name, date of birth, sex, marital status, address, employer, home and work telephone numbers, and emergency contact.
- Legible signatures and credentials of Provider and other staff members within a paper chart.
- All Providers who participate in the Member's care.
- Information about services delivered by these Providers.
- Weight and height information and, as appropriate, growth charts.
- A problem list that describes the Member's medical and behavioral health conditions.
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other Providers.
- Prescribed medications, including dosages and dates of initial or refill prescriptions.
- Medication reconciliation within 30 days of an inpatient discharge should include evidence of current and discharge medication reconciliation and the date performed.
- Allergies and adverse reactions (or notation that none are known).
- Documentation that Advanced Directives, Power of Attorney, and Living Will have been discussed with Member, and a copy of Advance Directives when in place.
- Past medical and surgical history, including physical examinations, treatments, preventive services, and risk factors.
- Treatment plans that are consistent with diagnosis.
- A working diagnosis that is recorded with the clinical findings.
- Pertinent history for the presenting problem.
- Pertinent physical exam for the presenting problem.
- Lab and other diagnostic tests that are ordered as appropriate by the Provider.
- Clear and thorough progress notes that state the intent for all ordered services and treatments.
- Notations regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or as needed, included in the next preventative care visit when appropriate.
- Notes from consultants, if applicable.
- Up-to-date immunization records and documentation of appropriate history.
- All staff and Provider notes are signed physically or electronically with either name or initials.
- All entries are dated.
- All abnormal lab/imaging results show explicit follow up plan(s).
- All ancillary services reports.
- Documentation of all emergency care provided in any setting.
- Documentation of all hospital admissions, inpatient and outpatient, including the hospital discharge summaries, hospital history and physicals, and operative report.
- Labor and delivery record for any child seen since birth.

- Family planning and counseling, obstetrical history, and profile.
- A signed document stating with whom protected health information may be shared.

Organization
- The medical record is legible to someone other than the writer.
- Each patient has an individual record.
- Chart pages are bound, clipped, or attached to the file.
- Chart sections are easily recognized for retrieval of information.
- A release document for each Member authorizing Molina to release medical information for facilitation of medical care.

Retrieval
- The medical record is available to Provider at each encounter.
- The medical record is available to Molina for purposes of quality improvement.
- The medical record is available to Illinois Department of Healthcare and Family Services and the external quality review organization upon request.
- The medical record is available to the Member upon his/her request.
- A storage system for inactive Member medical records that allows retrieval within 24 hours, is consistent with state and federal requirements, and the record is maintained for not less than ten (10) years from the last date of treatment—or for a minor, one (1) year past his/her 20th birthday but never less than ten (10) years.
- An established and functional data recovery procedure in the event of data loss.

Confidentiality
Molina Providers shall develop and implement confidentiality procedures to guard Member Protected Health Information (PHI) in accordance with HIPAA privacy standards and all other applicable federal and state regulations. This should include, and is not limited to, the following:
- Ensure that medical information is released only in accordance with applicable federal or state law in pursuant to court orders or subpoenas.
- Maintain records and information in an accurate and timely manner.
- Ensure timely access by Members to the records and information that pertain to them.
- Abide by all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information.
- Medical records are protected from unauthorized access.
- Access to computerized confidential information is restricted.
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.
- Education and training for all staff on handling and maintaining protected health care information.

Additional information on medical records is available from your local Molina Quality department at **(855) 866-5462**. For additional information regarding HIPAA, please see the Compliance section of this Provider Manual.

Access to Care

Molina maintains Access to Care standards and processes for ongoing monitoring of access to health care (including behavioral health care) provided by contracted PCPs (adult and pediatric) and participating specialists (to include OB/GYN, behavioral health Providers, and high-volume and high-impact specialists). Providers are required to conform to the Access to Care appointment standards listed below to ensure that health care services are provided in a timely manner. The standards are based on 90% availability for Emergency Services and 90% or greater for all other services. The PCP or his/her designee must be available 24 hours a day, seven (7) days a week to Members.

Appointment Access

All Providers who oversee the Member's health care are responsible for providing the following appointments to Molina Members in the time frames noted:

Medical Appointment Types	Standard
Routine preventive care	Within five (5) weeks from the date of request
Routine preventive care for infant under 6 months of age	Within two (2) weeks from the date of request
Routine, symptomatic, but not deemed serious	Within three (3) weeks from the date of request
Urgent care	Within 24 hours
After-hours care	24 hours/day 7 days/week availability
Specialty care (high volume)	Within three (3) weeks from the date of request (for complaints not deemed serious)
Specialty care (high impact)	Within three (3) weeks from the date of request (for complaints not deemed serious)
Urgent specialty care	Within 24 hours
Initial prenatal visit—first trimester	Within two (2) weeks from the date of request
Initial prenatal visit—second trimester	Within one (1) week from the date of request
Initial prenatal visit—third trimester	Within three (3) days from the date of request
Behavioral Health Appointment Types	**Standard**
Life-threatening emergency	Immediately
Non-life threatening emergency	Within six (6) hours
Urgent care	Within 24 hours
Initial routine care visit	Within 14 business days
Follow-up routine care visit	Within 30 calendar days

Additional information on appointment access standards is available from your local Molina Quality department at **(855) 866-5462**.

Office Wait Time
For scheduled appointments, the wait time in offices until seen by the PCP should not exceed 60 minutes from appointment time. All PCPs are required to monitor waiting times and adhere to this standard.

After Hours
All Providers must have back-up (on call) coverage after hours, or during the Provider's absence or unavailability. Molina requires Providers to maintain a 24-hour telephone service seven days per week. The Provider must have a published after-hours telephone number. This access may be through an answering service or other arrangements. The service or recorded message should instruct Members with an emergency to hang up and **call 911** or go immediately to the nearest Emergency Room. Voicemail alone after hours is not acceptable.

Appointment Scheduling
Each Provider must implement an appointment scheduling system. The following are the minimum standards:

1. The Provider must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments.
2. A process for documenting missed appointments must be established. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record, and the Provider is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the medical record. If a second appointment is missed, the Provider **must** notify the Molina Provider Network Management department at **(855) 866-5462** or TTY/TDD 711.
3. When the Provider must cancel a scheduled appointment, the Member is given the option of seeing an associate or having the next available appointment time.
4. Special needs of Members must be accommodated when scheduling appointments. This includes but is not limited to wheelchair-using Members and Members requiring language translation.
5. A process for Member notification of preventive care appointments must be established. This includes but is not limited to immunizations and mammograms.
6. A process must be established for Member recall in the case of missed appointments for a condition that requires treatment, abnormal diagnostic test results, or the scheduling of procedures that must be performed prior to the next visit.

In applying the standards listed above, Participating Providers have agreed that they will not discriminate against any Member on the basis of age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental, or sensory handicap, gender identity, pregnancy, sex stereotyping, place of residence, socioeconomic status, or status as a recipient of Medicaid benefits. Additionally, a Participating Provider or contracted medical group/IPA may not limit his/her practice because of a Member's medical (physical or mental) condition or the expectation of the

need for frequent or high-cost care. If a PCP chooses to close his/her panel to new Members, Molina must receive 30 days advance written notice from the Provider.

Women's Health Access
Molina allows Members the option to seek obstetric and gynecological care from an in-network obstetrician or gynecologist, or directly from a participating PCP designated by Molina as providing obstetrical and gynecological services. Member access to obstetrical and gynecological services is monitored to ensure Members have direct access to Participating Providers for obstetrical and gynecological services. Gynecological services must be provided when requested regardless of the gender status of the Member.

Additional information on Access to Care is available under the Resources tab on the Molinahealthcare.com website or from your local Molina Quality department, which can be reached at **(855) 866-5462.**

Monitoring Access for Compliance with Standards
Access to Care standards are reviewed, revised as necessary, and approved by the Quality Improvement Committee on an annual basis.

Provider Network adherence to access standards is monitored via one or more of the following mechanisms:
1. Provider access studies—Provider office assessment of appointment availability, after-hours access, Provider ratios, and geographic access.
2. Member complaint data—Assessment of Member complaints related to access to and availability of care.
3. Member satisfaction survey—Evaluation of Members' self-reported satisfaction with appointment and after-hours access.

Analysis of access data includes assessment of performance against established standards, review of trends over time, and identification of barriers. Results of analysis are reported to the Quality Improvement Committee at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for identified Provider-specific and/or organizational trends. Performance goals are reviewed and approved annually by the Quality Improvement Committee.

Additional information on Access to Care is available under the Health Resources tab on the Molinahealthcare.com website or is available from the Molina Quality department at **(855) 866-5462.**

Quality of Provider Office Sites
Molina Providers are to maintain office-site and medical record-keeping practices standards. Molina continually monitors Member complaints and appeals/grievances for all office sites to determine the need for an office site visit and will conduct office site visits as needed. Molina assesses the quality, safety, and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This includes an assessment of:

- Physical accessibility.
- Physical appearance.
- Adequacy of waiting and examining room space.

Physical Accessibility
Molina evaluates office sites as applicable to ensure that Members have safe and appropriate access to the office site. This includes, but is not limited to, ease of entry into the building, accessibility of space within the office site, and ease of access for physically disabled patients.

Physical Appearance
The site visits include, but are not limited to, an evaluation of office site cleanliness, appropriateness of lighting, and patient safety as needed.

Adequacy of Waiting and Examining Room Space
During the site visit, as required, Molina assesses waiting and examining room spaces to ensure that the office offers appropriate accommodations to Members. The evaluation includes, but is not limited to, appropriate seating in the waiting room areas and availability of exam tables in exam rooms.

Administration & Confidentiality of Facilities
Facilities contracted with Molina must demonstrate an overall compliance with the guidelines listed below:
- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted, and parking area and walkways demonstrate appropriate maintenance.
- Accessible parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is handicapped accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two office exam rooms per Provider.
- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and epinephrine, plus any other medications appropriate to the practice.
- At least one CPR-certified employee is available
- Yearly OSHA training (fire, safety, bloodborne pathogens, etc.) is documented for offices with ten (10) or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, and contracts evidence hazardous waste management.
- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers, or labels are possible alternative methods.
- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.
- Medical records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked.
- A CLIA waiver is displayed when the appropriate lab work is run in the office.

- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double-locked. Medication and sample access are restricted.
- A system is in place to ensure expired sample medications are not dispensed, and injectables and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

Advance Directives (Patient Self-Determination Act)
Molina complies with the Advance Directives requirements of the states in which the organization provides services. Responsibilities include ensuring Members receive information regarding Advance Directives and that contracted Providers and facilities uphold executed documents.

Advance Directives are a written choice for health care. Illinois has four (4) types of Advance Directives:
- **Health Care Power of Attorney**—Allows an agent to be appointed to carry out health care decisions.
- **Living Will**—Allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration.
- **Do-Not-Resuscitate Order (DNR)**—A medical order stating that cardiopulmonary resuscitation cannot be performed if the heart or breathing stops.
- **Mental Health Treatment Preference Declaration**—Allows the Member to state whether they want to receive electroconvulsive treatment or psychotropic medicine.

When There Are No Advance Directives
The Member's family and Provider will work together to decide on the best care for the Member based on information they may know about the Member's end-of-life plans.

Providers must inform adult Molina Members 18 years of age and up of their right to make health care decisions and execute advance directives. It is important that Members are informed about advance directives.

New adult Members or their identified personal representative will receive educational information and instructions on how to access Advance Directives forms in their Member Handbook, Evidence of Coverage (EOC), and other Member communications, such as newsletters and the Molina website. If a Member is incapacitated at the time of enrollment, Molina will provide Advance Directive information to the Member's family or representative and will follow up with information to the Member at the appropriate time. All current Members will receive annual notice explaining this information, in addition to newsletter information.

Members who would like more information are instructed to contact Member Services or are directed to the CaringInfo website at caringinfo.org/stateaddownload for forms available to download. Additionally, the Molina website offers information to both Providers and Members regarding Advance Directives, with a link to forms that can be downloaded and printed.

PCPs must discuss advance directives with a Member and provide appropriate medical advice if the Member desires guidance or assistance.

Molina network Providers and facilities are expected to communicate any objections they may have to a Member directive prior to service when possible. Members may select a new PCP if the assigned Provider has an objection to the Member's desired decision. Molina will facilitate finding a new PCP or specialist as needed.

In no event may any Provider refuse to treat a Member or otherwise discriminate against a Member because the Member has completed an advance directive. CMS law gives Members the right to file a complaint with Molina or the state's survey and certification agency if the Member is dissatisfied with Molina's handling of advance directives and/or if a Provider fails to comply with advance directives instructions.

Molina will notify the Provider via fax of an individual Member's advance directives identified through Care Management, Care Coordination, or Care Management. Providers are instructed to document the presence of an advance directive in a prominent location of the medical record. Auditors will also look for copies of the advance directives form. Advance directives forms are state specific to meet state regulations.

Molina will look for documented evidence of the discussion between the Provider and the Member during routine medical record reviews.

EPSDT Services to Enrollees Under 21 Years
Molina maintains systematic and robust monitoring mechanisms to ensure all required Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services to Enrollees under 21 years of age are timely according to required preventive guidelines. All Enrollees under 21 years of age should receive preventive, diagnostic, and treatment services at intervals as set forth in Section 1905(R) of the Social Security Act. Molina's Quality or the Provider Network Management department is also available to perform Provider training to ensure that best-practice guidelines are followed in relation to well-child services and care for acute and chronic health care needs.

Well Child/Adolescent Visits
Visits consist of age-appropriate components that include but are not limited to:

- Comprehensive health and developmental history.
- Nutritional assessment.
- Height, weight, and growth charting.
- Comprehensive unclothed physical examination.
- Appropriate immunizations according to the Advisory Committee on Immunization Practices.
- Laboratory procedures, including lead blood level assessment appropriate for age and risk factors.
- Periodic developmental and behavioral screening using a recognized, standardized developmental screening tool.
- Vision and hearing tests.

- Dental assessment and services.
- Health education, including anticipatory guidance, such as child development, healthy lifestyles, and accident and disease prevention.

Diagnostic services, treatment, or services medically necessary to correct or ameliorate defects, physical or mental illnesses, and conditions discovered during a screening or testing must be provided or arranged for either directly or through referrals. Any condition discovered during the screening examination or screening test requiring further diagnostic study or treatment must be provided if within the Member's Covered Benefit Services. Members should be referred to an appropriate source of care for any required services that are not Covered Services.

Molina shall have no obligation to pay for services that are not Covered Services.

Monitoring for Compliance with Standards
Molina monitors compliance with the established performance standards as outlined above at least annually. Within 30 calendar days of the review, a copy of the review report and a letter will be sent to the medical group notifying them of their results. Performance below Molina's standards may result in a Corrective Action Plan (CAP) with a request that the Provider submit a written Corrective Action Plan to Molina within 30 calendar days. Follow up to ensure resolution is conducted at regular intervals until compliance is achieved. The information and any response made by the Provider are included in the Providers permanent credentials file. If compliance is not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from network participation or closed to new Members.

Quality Improvement Activities and Programs
Molina maintains an active Quality Improvement Program. The Quality Improvement Program provides structure and key processes to carry out our ongoing commitment to improvement of care and service. The goals identified are based on an evaluation of programs and services; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

Health Management and Care Management
The Molina Health Management and Care Management Programs provide for the identification, assessment, stratification, and implementation of appropriate interventions for Members with chronic diseases. For additional information, please see the Health Management heading in the Health Care Services section of this Provider Manual.

Clinical Practice Guidelines
Molina adopts and disseminates Clinical Practice Guidelines (CPGs) to reduce inter-Provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of medical literature, and/or appropriately established authority. CPGs are reviewed at least annually and more frequently as needed, when clinical evidence changes and is approved by the Quality Improvement Committee.

Molina CPGs include the following:

- Acute stress and Post-Traumatic Stress Disorder (PTSD).
- Anxiety/panic disorder.
- Asthma.
- Attention Deficit Hyperactivity Disorder (ADHD).
- Bipolar disorder.
- Chronic kidney disease.
- Chronic Obstructive Pulmonary Disease (COPD).
- Community reintegration and support.
- Coordination of community support and services for Enrollees in HCBS waivers.
- Coronary artery disease (CAD).
- Dental services.
- Depression.
- Detoxification and substance abuse treatment.
- Diabetes.
- Heart failure.
- Hypertension.
- Long-Term Care (LTC) residential coordination of services.
- Mental health.
- Obesity.
- Opioid management.
- Perinatal/prenatal/postnatal care.
- Pharmacy services.
- Prenatal, obstetrical, postpartum, and reproductive health care.
- Psychotropic medication management.
- Sickle cell disease.
- Smoking cessation.

The adopted CPGs are distributed to the appropriate Providers, Provider groups, staff model facilities, delegates, and Members by the Quality, Provider Network Management, Health Education, and Member Services departments. The guidelines are disseminated through Provider newsletters, Just the Fax electronic bulletins, and other media and are available on the Molina website. Individual Providers or Members may request copies from the Molina Quality department at **(855) 866-5462**.

Preventive Health Guidelines

Molina provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF) Bright Futures/American Academy of Pediatrics, and Centers for Disease Control and Prevention (CDC), in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines. Diagnostic preventive procedures include, but are not limited to:

- Care for children up to 24 months old.
- Care for children two (2) to 19 years of age.
- Care for adults 20 to 64 years of age.
- Care for adults 65 years and older.

- Immunization schedules for children and adolescents.
- Immunization schedules for adults.

Clinical practice guidelines are updated at least annually—and more frequently as needed when clinical evidence changes—and updates are approved by the Quality Improvement Committee. On annual basis, Preventive Health Guidelines are distributed to Providers at MolinaHealthcare.com and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Provider Newsletter.

Cultural and Linguistic Services
Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. For additional information about Molina's programs and services, please see the Cultural Competency and Linguistic Services section of this Provider Manual.

Measurement of Clinical and Service Quality
Molina monitors and evaluates the quality of care and services provided to Members through the following mechanisms:
- Healthcare Effectiveness Data and Information Set® (HEDIS®).
- Consumer Assessment of Healthcare Providers and Systems® (CAHPS®).
- Behavioral health survey
- Provider satisfaction survey
- Effectiveness of quality improvement initiatives

Molina evaluates continuous performance according to or in comparison with objectives, measurable performance standards, and benchmarks at the national, regional, and/or local/health plan level.

Contracted Providers and facilities must allow Molina to use their performance data collected in accordance with the Provider's or facility's contract. The use of performance data may include but is not limited to: (1) development of quality improvement activities, (2) public reporting to consumers, (3) preferred status designation in the network, (4) and/or reduced Member cost-sharing.

Molina's most recent results can be obtained from Molina Quality staff at **(855) 866-5462** or fax **(855) 556-2074** or by visiting our website at MolinaHealthcare.com.

Healthcare Effectiveness Data and Information Set (HEDIS®)
Molina utilizes the NCQA© HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of Managed Care Organization performance. HEDIS® is an annual activity conducted in the spring. The data comes from on-site medical record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of health care aspects, including immunizations, women's health screening, diabetes care, well check-ups, medication use, and cardiovascular disease.

HEDIS® results are used in a variety of ways. The results are the measurement standard for many of Molina's clinical quality activities and health improvement programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the success of these programs.

Selected HEDIS® results are provided to regulatory and accreditation agencies as part of our contracts with these agencies. The data are also used to compare to established health plan performance benchmarks.

Consumer Assessment of Healthcare Providers and Systems® (CAHPS®)
CAHPS® is the tool used by Molina to summarize Member satisfaction with the health care and service they receive. CAHPS® examines specific measures, including getting needed care, getting care quickly, how well doctors communicate, coordination of care, customer service, rating of health care, and getting needed prescription drugs. The CAHPS® survey is administered annually in the spring to randomly selected Members by an NCQA-certified vendor.

CAHPS® results are used in much the same way as HEDIS® results, only the focus is on the service aspect of care rather than clinical activities. They form the basis for several of Molina's quality improvement activities and are used by external agencies to help ascertain the quality of services being delivered.

Behavioral Health Survey
Molina obtains feedback from Members about their experience, needs, and perceptions regarding behavioral health care. This feedback is collected at least annually to help us understand how our Members rate their experiences in getting treatment, communicating with their clinicians, receiving treatment and information from the plan, and perceived improvement, among other areas.

Provider Satisfaction Survey
Recognizing that HEDIS® and CAHPS® Qualified Health Plan Enrollee Experience Surveys both focus on Member experience with health care Providers and health plans, Molina conducts a Provider satisfaction survey annually. The results from this survey are important to Molina, as this is one of the primary methods used to identify improvement areas pertaining to the Molina Provider Network.

The survey results have helped establish improvement activities relating to Molina's specialty network, inter-Provider communications, and pharmacy authorizations. This survey is fielded to a random sample of Providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

Effectiveness of Quality Improvement Initiatives
Molina monitors the effectiveness of clinical and service activities through metrics selected to demonstrate clinical outcomes and service levels. The plan's performance is compared to that of available national benchmarks indicating "best practices." The evaluation includes an assessment of clinical and service improvements on an ongoing basis. Results of these measurements guide activities for the successive periods.

In addition to the methods described above, Molina also compiles complaint and appeals data, as well as data on requests for out-of-network services to determine opportunities for service improvements.

What Can Providers Do?

- Ensure that patients are up to date with their annual physical exam and preventive health screenings, including related lab orders and referrals to specialists, such as ophthalmology.
- Review the HEDIS® preventive care listing of measures for each patient to determine if anything applicable to your patient's age and/or condition has been missed.
- Check that staff is properly coding all services provided.
- Be sure that patients understand what **they** need to do.

Molina has additional resources to assist Providers and their patients. For access to tools that can assist, please visit the Provider Portal. In it are a variety of resources, including HEDIS® CPT/CMS-approved diagnostic and procedural code sheets. To obtain a current list of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey Star Ratings measures, contact Molina's Quality department.

11. Risk Adjustment Management Program

What is Risk Adjustment?
The Centers for Medicare & Medicaid Services (CMS) defines risk adjustment as a process that helps accurately measure the health status of a plan's membership based on medical conditions and demographic information.

This process helps ensure that health plans receive accurate payment for services provided to Molina Members and prepares for resources that may be needed in the future to treat Members who have multiple clinical conditions.

Why is Risk Adjustment Important?
Molina relies on our Provider Network to take care of our Members based on their health care needs. Risk adjustment looks at a number of clinical data elements of a Member's health profile to determine any documentation gaps from past visits and identifies opportunities for gap closure for future visits. In addition, risk adjustment allows us to:

- Focus on quality and efficiency.
- Recognize and address current and potential health conditions early.
- Identify Members for care management referral.
- Ensure adequate resources for the acuity levels of Molina Members.
- Have the resources to deliver the highest quality of care to Molina Members.

Your Role as a Provider
As a Provider, your complete and accurate documentation in a Member's medical record and submitted claims is critical to a Member's quality of care. We encourage Providers to code all diagnoses to the highest specificity, as this will ensure that Molina receives adequate resources to provide quality programs to you and our Members.

For a complete and accurate medical record, all Provider documentation **must**:

- Address clinical data elements (e.g., diabetic patient needs an eye exam or multiple comorbid conditions) provided by Molina and reviewed with the Member.
- Be compliant with CMS correct coding initiative.
- Use the correct ICD-10 code by coding the condition to the highest level of specificity.
- Only use diagnosis codes confirmed during a face-to-face visit with the Member.
- Contain a treatment plan and progress notes.
- Contain the Member's name and date of service.
- Have the Provider's signature and credentials.

Risk Adjustment Data Validation (RADV) Audits
As part of the regulatory process, state and/or federal agencies may conduct Risk Adjustment Data Validation (RADV) audits to ensure that the diagnosis data submitted by Molina is appropriate and accurate. All claims/encounters submitted to Molina are subject to state and/or federal and internal health plan auditing. If Molina is selected for a RADV audit, Providers will be required to submit medical records in a timely manner to validate the previously submitted data.

Contact Information
For questions about Molina's Risk Adjustment Programs, please contact our team at RiskAdjustment.Programs@MolinaHealthcare.com.

12. Cultural Competency and Linguistic Services

Background
Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the U.S. Department of Health and Human Services (HHS), Office of Minority Health (OMH) guides the activities to deliver culturally competent services.

Molina complies with Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA), and other regulatory/contract requirements. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency (LEP) and Members who are deaf, hard of hearing, non-verbal, have a speech impairment, or have an intellectual disability.

Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds, genders, gender identities, sexual orientations, ages, and religions, as well as those with disabilities in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on cultural competency and linguistic services is available at MolinaHealthcare.com, from your Provider Network Manager, or by calling Molina's Provider Network Management department at **(855) 866-5462**.

Nondiscrimination of Health Care Service Delivery
Molina complies with the guidance set forth in the final rule for Section 1557 of the ACA, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina website homepages.

All Providers who join the Molina Provider Network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Molina requires Providers to deliver services to Molina Members without regard to race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, or source of payment. Providers must post a nondiscrimination notification in a conspicuous location in their office, along with translated non-English taglines in the top 15 languages spoken in the state to ensure that Molina Members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred.

Additionally, Participating Providers or contracted medical groups/Independent Physician Associations (IPAs) may not limit their practices because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.

Providers can refer Molina Members who are complaining of discrimination to the Molina Civil Rights Coordinator at **(866) 606-3889** (TTY 711).

Members can email the complaint to civil.rights@MolinaHealthcare.com.

Members can mail their complaint to Molina:

Molina Healthcare Inc.
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802

Members can also file a civil rights complaint with the HHS, OCR. Complaint forms are available at hhs.gov/ocr/complaints/index.html. The form can be mailed to:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201

Members can also send it to a website through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf.

If you or a Molina Member need help, call **(800) 368-1019** or TTY **(800) 537-7697**.

Should you or a Molina Member need more information, refer to the Health and Human Services website: federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority.

Cultural Competency

Molina is committed to reducing health care disparities. Training employees, Providers, and their staff, and monitoring quality are the cornerstones of successful, culturally competent service delivery. Molina integrates cultural competency training into the overall Provider training and quality-monitoring programs. An integrated quality approach enhances the way people think about our Providers, service delivery, and program development so that cultural competency becomes a part of everyday thinking.

Provider and Community Training

Molina offers educational opportunities in cultural competency concepts for Providers, their staff, and community-based organizations. Molina conducts Provider training during Provider orientation, plus annual reinforcement training offered through Provider Network Management or with online training modules.

Training modules, delivered through a variety of methods, include:

1. Provider-written communications and resource materials.
2. On-site cultural competency training.
3. Online cultural competency Provider training modules.
4. Integration of cultural competency concepts and nondiscrimination of service delivery into Provider communications.

Integrated Quality Improvement—Ensuring Access
Molina ensures Member access to language services, such as oral interpretation, American Sign Language (ASL), and written translation. Molina must also ensure access to programs, aids, and services that are congruent with cultural norms. Molina supports Members with disabilities and assists Members with LEP.

Molina develops Member materials according to Plain Language Guidelines. Members or Providers may also request written Member materials in alternate languages and formats (i.e., braille, audio, large print), leading to better communication, understanding, and Member satisfaction. Online materials found on MolinaHealthcare.com and information delivered in digital form meet Section 508 accessibility requirements to support Members with visual impairments.

Key Member information, including appeal and grievance forms, are also available in threshold languages on the Molina Member website.

Program and Policy Review Guidelines
Molina conducts assessments of the following information at regular intervals to ensure its programs are most effectively meeting the needs of its Members and Providers.

- Annual collection and analysis of race, ethnicity, and language data from:
  - Eligible individuals to identify significant culturally and linguistically diverse populations within a plan's membership.
  - Contracted Providers to assess gaps in network demographics.
- Revalidate data at least annually.
- Local geographic population demographics and trends derived from publicly available sources (community health measures and state rankings report).
- Applicable national demographics and trends derived from publicly available sources.
- Assessment of Provider Network.
- Collection of data and reporting for the Diversity of Membership HEDIS® measure.
- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages.
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations.
- Analysis of HEDIS® and CAHPS® Qualified Health Plan Enrollee Experience survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

Access to Interpreter Services
Providers may request interpreters for Members whose primary language is other than English by calling Molina's Contact Center toll free at **(855) 687-7861**. If Contact Center Representatives are unable to interpret in the requested language, the Representative will immediately connect you and the Member to a qualified language service Provider.

Molina Providers must support Member access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset. Providers may offer interpreter services to Molina Members if the Members do not

request them on their own. Please remember it is never permissible to ask a family member, friend, or minor to interpret.

Documentation
As a contracted Molina Provider, your responsibilities for documenting Member language services/needs in the Member's medical record are as follows:

- Record the Member's language preference in a prominent location in the medical record. This information is provided to you on the electronic Member lists that are sent to you each month by Molina.
- Document all Member requests for interpreter services.
- Document who provided the interpreter service. This includes the name of Molina's internal staff or someone from a commercial interpreter service vendor. Information should include the interpreter's name, operator code, and vendor.
- Document all counseling and treatment done using interpreter services.
- Document if a Member insists on using a family member, friend, or minor as an interpreter, or refuses the use of interpreter services after notification of his/her right to have a qualified interpreter at no cost.

Members Who Are Deaf or Hard of Hearing
Molina provides a TTY/TDD connection accessible by dialing 711. This connection provides access to the Member and Provider Contact Center, Quality, Health Care Services, and all other health plan functions.

Molina strongly recommends that Provider offices make assistive listening devices available for Members who are deaf or hard of hearing. Assistive listening devices enhance the sound of the Provider's voice to facilitate a better interaction with the Member.

Molina will provide face-to-face service delivery for ASL to support our Members who are deaf or hard of hearing. Requests should be made three (3) business days in advance of an appointment to ensure availability of the service. In most cases, Members will have made this request via Molina Member Services.

Nurse Advice Line
Molina provides 24/7 Nurse Advice Services for Members. The Nurse Advice Line provides access to 24-hour interpretive services. Members may call Molina's Nurse Advice Line directly: English **(888) 275-8750** or TTY/TDD 711, Spanish **(866) 648-3537**. The Nurse Advice Line telephone numbers are also printed on membership cards.

13. Compliance

Fraud, Waste, and Abuse

Introduction

Molina is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, Molina's Compliance department maintains a comprehensive plan that addresses how Molina will uphold and follow state and federal statutes and regulations pertaining to fraud, waste, and abuse. The plan also addresses fraud, waste, and abuse prevention and detection, along with the education of appropriate employees, vendors, Providers, and associates doing business with Molina.

Molina's Special Investigation Unit (SIU) supports compliance in its efforts to deter and prevent fraud, waste, and abuse by conducting investigations aimed at identifying suspect activity and reporting these findings to the appropriate regulatory and/or law enforcement agency.

Mission Statement

Molina regards health care fraud, waste, and abuse as unacceptable, unlawful, and harmful to the provision of quality health care in an efficient and affordable manner. Molina has therefore implemented a plan to prevent, investigate, and report suspected health care fraud, waste, and abuse in order to reduce health care cost and to promote quality health care.

Regulatory Requirements

Federal False Claims Act

The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

The term "knowing" is defined to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the claim.
- Acts in deliberate ignorance of the truth or falsity of the information in a claim.
- Acts in reckless disregard of the truth or falsity of the information in a claim.

The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care Providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished, or otherwise causing a false claim to be submitted.

Deficit Reduction Act

The Deficit Reduction Act (DRA) aims to cut fraud, waste, and abuse from the Medicare and Medicaid Programs.

As a contractor doing business with Molina, Providers and their staff have the same obligation to report any actual or suspected violation of Medicare/Medicaid funds either by fraud, waste, or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and state laws pertaining to submitting false claims.
- How Providers will detect and prevent fraud, waste, and abuse.
- Employee protection rights as whistleblowers.

These provisions encourage employees (current or former) and others to report instances of fraud, waste, or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims Act. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed, or otherwise discriminated against due to their role in disclosing or reporting a false claim are entitled to all relief necessary to make the employee whole, including:

- Employment reinstatement at the same level of seniority.
- Two times the amount of back pay, plus interest.
- Compensation for special damages incurred by the employee as a result of the employer's inappropriate actions.

Affected entities who fail to comply with the law will be at risk of forfeiting all Medicaid payments until compliance is met. Molina will take steps to monitor Molina-contracted Providers to ensure compliance with the law.

Anti-Kickback Statute—Provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable or reimbursable under the Medicare or other federal health care programs.

Stark Statute—Similar to the Anti-Kickback Statute, but more narrowly defined and applied. It applies specifically to services **provided only by physicians**, rather than by all health care Providers.

Sarbanes-Oxley Act of 2002—Requires certification of financial statements by both the Chief Executive Officer and the Chief Financial Officer. The act states that a corporation must assess the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

Definitions

Fraud—An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law. (42 CFR § 455.2)

Waste—Health care spending that can be eliminated without reducing the quality of care. Quality waste includes overuse, underuse, and ineffective use. Inefficiency waste includes redundancy, delays, and unnecessary process complexity. An example would be the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent; however, the outcome resulted in poor or inefficient billing methods (e.g., coding) causing unnecessary costs to the Medicaid Program.

Abuse—Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary costs to the Medicaid Program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid Programs. (42 CFR § 455.2)

Examples of Fraud, Waste, and Abuse by a Provider
The types of questionable Provider schemes investigated by Molina include, but are not limited to:

- A Provider knowingly and willfully referring a Member to health care facilities in which or with which the Provider has a financial relationship (Stark Law).
- Altering claims and/or medical record documentation to get a higher level of reimbursement.
- Balance billing a Molina Member for Covered Services. This includes asking the Member to pay the difference between the discounted and negotiated fees and the Provider's usual and customary fees.
- Billing for and providing services to Members that are not medically necessary.
- Billing for services, procedures, and/or supplies that have not been rendered or used.
- Billing under an invalid place of service to receive or maximize reimbursement.
- Completing certificates of medical necessity for Members not personally and professionally known by the Provider.
- Concealing a Member's misuse of a Molina identification card.
- Failing to report a Member's forgery or alteration of a prescription or other medical document.
- False coding to receive or maximize reimbursement.
- Inappropriate billing of modifiers to receive or maximize reimbursement.
- Inappropriate billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement.
- Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients.
- Not following incident to billing guidelines in order to receive or maximize reimbursement.
- Overutilization.
- Participating in schemes that involve collusion between a Provider and a Member that result in higher costs or charges.
- Questionable prescribing practices.

- Unbundling services to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code.
- Underutilization, which means failing to provide services that are medically necessary.
- Upcoding, which is when a Provider does not bill the correct code for the service rendered, and instead uses a code for a like service that costs more.
- Using the adjustment payment process to generate fraudulent payments.

Examples of Fraud, Waste, and Abuse by a Member
The types of questionable Member schemes investigated by Molina include, but are not limited to:
- Benefit sharing with persons not entitled to the Member's benefits.
- Conspiracy to defraud Medicaid.
- Doctor shopping, which occurs when a Member consults a number of Providers for the purpose of inappropriately obtaining services.
- Falsifying documentation to get services approved.
- Forgery related to health care.
- Prescription diversion, which occurs when a Member obtains a prescription from a Provider for a condition that they do not suffer from and the Member sells the medication to someone else.

Review of Provider Claims and Claims System
Molina Claims Examiners are trained to recognize unusual billing practices and to detect fraud, waste, and abuse. If the Claims Examiner suspects fraudulent, abusive, or wasteful billing practices, the billing practice is documented and reported to the Compliance department.

The claims payment system utilizes system edits and flags to validate that elements of claims are billed in accordance with standardized billing practices, ensure that claims are processed accurately, and ensure that payments reflect the service performed as authorized.

Molina performs auditing to ensure the accuracy of data input into the claims system. The Claims department conducts regular audits to identify system issues or errors. If errors are identified, they are corrected, and a thorough review of system edits is conducted to detect and locate the source of the errors.

Prepayment Fraud, Waste, and Abuse Detection Activities
Through implementation of claims edits, Molina's claims payment system is designed to audit claims concurrently in order to detect and prevent paying claims that are inappropriate.

Molina has a prepayment claims auditing process that identifies frequent correct coding billing errors, ensuring that claims are coded appropriately according to state and federal coding guidelines. Code edit relationships and edits are based on guidelines from specific state Medicaid Guidelines, Centers for Medicare & Medicaid Services

(CMS), federal CMS guidelines, AMA, and published specialty specific coding rules. Code edit rules are based on information received from the National Physician Fee Schedule (NPFS) relative file, the Medically Unlikely Edit (MUE) table, the Medicaid National Correct Coding Initiative (NCCI) files, and state-specific policy manuals and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).

Additionally, Molina may, at the request of a state program or at its own discretion, subject a Provider to prepayment reviews, whereupon the Provider is required to submit supporting source documents that justify an amount charged. Where no supporting documents are provided or insufficient information is provided to substantiate a charge, the claim will be denied until such time that the Provider can provide sufficient accurate support.

Post-Payment Recovery Activities
The terms expressed in this section of this Provider Manual are incorporated into the Provider Agreement and are intended to supplement, rather than diminish, any and all other rights and remedies that may be available to Molina under the Provider Agreement or at law or equity.

In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement, the parties agree that Molina shall, at its sole discretion, exercise the terms that are expressed in the Provider Agreement, the terms that are expressed here, its rights under law and equity, or some combination thereof.

Provider will provide Molina, and governmental agencies and their representatives or agents, access to examine, audit, and copy any and all records deemed by Molina, at Molina's sole discretion, necessary to determine compliance with the terms of the Provider Agreement, including for the purpose of investigating potential fraud, waste, and abuse. Documents and records must be readily accessible at the location where Provider provides services to any Molina Members. Auditable documents and records include, but are not limited to, medical charts, patient charts, billing records, and coordination of benefits information. Production of auditable documents and records must be provided in a timely manner, as requested by Molina, and without charge to Molina. In the event Molina identifies fraud, waste, or abuse, Provider agrees to repay funds or Molina may seek recoupment.

If a Molina auditor is denied access to Provider's records, all of the claims for which Provider received payment from Molina are immediately due and owing. If Provider fails to provide all requested documentation for any claim, the entire amount of the paid claim is immediately due and owing. Molina may offset such amounts against any amounts owed by Molina to Provider. Provider must comply with all requests for documentation and records without delay (as reasonably requested by Molina) and without charge to Molina. Claims for which Provider fails to furnish supporting documentation during the audit process are not reimbursable and are subject to chargeback.

Provider acknowledges that HIPAA specifically permits a covered entity, such as Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 154.501). Provider further acknowledges that in order to receive payment from Molina, Provider is required to allow Molina to conduct audits of its pertinent records to verify the services performed and the payment claimed, and that such audits are permitted as a payment activity of Provider under HIPAA and other applicable privacy laws.

Claim Auditing
Molina shall use established industry claims adjudication and/or clinical practices, state and federal guidelines, and/or Molina's policies and data to determine the appropriateness of the billing, coding, and payment.

Provider acknowledges Molina's right to conduct pre- and post-payment billing audits. Provider shall cooperate with Molina's Special Investigations Unit and audits of claims and payments by providing access at reasonable times to requested claims information, all supporting medical records, Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, medical records upon Molina's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment.

In reviewing medical records for a procedure, Molina may select a statistically valid random sample or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of claims that Molina paid in error. The estimated proportion, or error rate, may be projected across all claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal claims review, client-directed/regulatory investigation, and/or compliance reviews and may be vendor assisted. Molina asks that you provide Molina, or Molina's designee, during normal business hours, access to examine, audit, scan, and copy any and all records necessary to determine compliance and accuracy of billing.

If Molina's Special Investigations Unit suspects fraudulent or abusive activity, Molina may conduct an on-site audit without notice. Should Provider refuse to allow access to facilities, Molina reserves the right to recover the full amount paid or due to Provider.

Provider Education
When Molina identifies through an audit or other means a situation with a Provider that is either inappropriate or deficient (e.g., coding, billing), Molina may determine that a Provider education visit is appropriate.

Molina will notify the Provider of the deficiency and will take steps to educate the Provider, which may include the Provider submitting a Corrective Action Plan (CAP) to Molina addressing the issues identified and how it will cure these issues moving forward.

Reporting Fraud, Waste, and Abuse
If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina AlertLine. AlertLine is an external telephone and web-based reporting system hosted by NAVEX Global, a leading Provider of compliance and ethics hotline services. AlertLine reporting is available 24/7/365. When you make a report, you can choose to remain confidential or anonymous. If you choose to call AlertLine, a trained professional at NAVEX Global will note your concerns and provide them to the Molina Compliance department for follow-up. If you elect to use the web-based reporting process, you will be asked a series of questions before submitting your report. Reports to AlertLine can be made from anywhere within the United States with telephone or internet access.

Molina AlertLine can be reached toll free at **(866) 606-3889** or you may use the service's website to make a report at any time at MolinaHealthcare.alertline.com.

You may also report cases of fraud, waste, or abuse to Molina's Compliance department. You have the right to have your concerns reported anonymously without fear of retaliation.

Molina Healthcare of Illinois, Inc.
Attn: Compliance
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523
Telephone: (888) 858-2156
Fax: (630) 571-1220

Include the following information when reporting:
- Nature of complaint.
- The names of individuals and/or entities involved in suspected fraud and/or abuse, including address, phone number, Molina Member ID number, and any other identifying information.

Suspected fraud and abuse may also be reported directly to the state at:

Illinois State Police
Medicaid Fraud Control Unit
8151 W. 183rd Street, Suite F
Tinley Park, IL 60477
Toll Free Phone: (844) 453-7283 – (844) ILFRAUD

Illinois Attorney General
Online at: illinois.gov/hfs/oig/Pages/ReportFraud.aspx

HIPAA Requirements and Information
HIPAA (Health Insurance Portability and Accountability Act)

Molina's Commitment to Patient Privacy
Protecting the privacy of Members' personal health information is a core responsibility that Molina takes very seriously. Molina is committed to complying with all federal and state laws regarding the privacy and security of Members' Protected Health Information (PHI).

Provider Responsibilities
Molina expects that its contracted Provider will respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable laws and regulations regarding the privacy of patient and Member PHI. Molina provides its Members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how Molina uses and discloses their PHI and includes a summary of how Molina safeguards their PHI.

Telehealth/telemedicine Providers: Telehealth transmissions are subject to HIPAA-related requirements outlined under state and federal law, including:
- 42 C.F.R. Part 2 Regulations.
- Health Information Technology for Economic and Clinical Health Act (HITECH Act).

Applicable Laws
Providers must understand all state and federal health care privacy laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that protects all health information in the United States; instead there is a patchwork of laws that Providers must comply with. In general, most health care Providers are subject to various laws and regulations pertaining to privacy of health information, including without limitation:

1. **Federal Laws and Regulations:**
    - HIPAA.
    - The Health Information Technology for Economic and Clinical Health Act (HITECH).
    - 42 C.F.R. Part 2.
    - Medicare and Medicaid laws.
    - The Affordable Care Act.
2. **State Medical Privacy Laws and Regulations:**
    - Providers should be aware that HIPAA provides a floor for patient privacy, but that state laws should be followed in certain situations, especially if the state law is more stringent than HIPAA. Providers should consult with their own legal counsel to address their specific situation.

Uses and Disclosure of PHI
Member and patient PHI should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a Provider may use and disclose PHI for their own health care Treatment, Payment, and Operations (TPO) activities without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity[1]. Disclosure of PHI by one covered entity to another covered entity, or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is

[1]See, Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule.

a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of services[2].

2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:
   - Quality improvement.
   - Disease management.
   - Care management and care coordination.
   - Training programs.
   - Accreditation, licensing, and credentialing.

Importantly, this allows Providers to share PHI with Molina for our health care operations activities, such as HEDIS® and Quality Improvement.

Confidentiality of Substance Use Disorder Patient Records
Federal regulations regarding confidentiality of Substance Use Disorder patients' records apply to any entity or individual providing federally assisted alcohol or drug abuse prevention treatment. Records of the identity, diagnosis, prognosis, or treatment of any patient that are maintained in connection with Substance Use Disorder treatment or programs are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects Substance Use Disorder information, the Federal Confidentiality of Substance Use Disorder Patients Records regulations are more restrictive than HIPAA, and they do not allow disclosure without the Member's written consent, except as set forth in 42 CFR Part 2.

Inadvertent Disclosures of PHI
Molina may, on occasion, inadvertently misdirect or disclose Protected Health Information (PHI) pertaining to Molina Member(s) who are not the patients of the Provider. In such cases, the Provider shall return or securely destroy the PHI of the affected Molina Members in order to protect their privacy. The Provider agrees to not further use or disclose such PHI and further agrees to provide an attestation of return or destruction and non-disclosure of any such misdirected PHI upon the reasonable request of Molina.

Written Authorizations
Uses and disclosures of PHI that are not permitted or required under applicable law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable state law.

Patient Rights
Patients are afforded various rights under HIPAA. Molina Providers must allow patients to exercise any of the below-listed rights that apply to the Provider's practice:

[2] See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule.

1. **Notice of Privacy Practices**
   Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the notice of privacy practices.
2. **Requests for Restrictions on Uses and Disclosures of PHI**
   Patients may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.
3. **Requests for Confidential Communications**
   Patients may request that a health care Provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests by the patient.
4. **Requests for Patient Access to PHI**
   Patients have a right to access their own PHI within a Provider's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider includes the patient's medical record, as well as billing and other records used to make decisions about the Member's care or payment for care.
5. **Request to Amend PHI**
   Patients have a right to request that the Provider amend information in their designated record set.
6. **Request Accounting of PHI Disclosures**
   Patients may request an accounting of disclosures of PHI made by the Provider during the preceding six-year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations or made prior to April 14, 2003.

HIPAA Security
Providers must implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of Molina Member and patient PHI. As more Providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate cybersecurity measures. Providers should recognize that identity theft—both financial and medical—is a rapidly growing problem, and that their patients trust their health care Providers to keep their most sensitive information private and confidential.

Medical identity theft is an emerging threat in the health care industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity—such as health insurance information—without the person's knowledge or consent to obtain health care services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to Molina.

HIPAA Transactions and Code Sets
Molina strongly supports the use of electronic transactions to streamline health care administrative activities. Molina Providers are strongly encouraged to submit claims and

other transactions to Molina using electronic formats. Certain electronic transactions in health care are subject to HIPAA's Transactions and Code Sets rule including, but not limited to:

- Claims and encounters.
- Member eligibility status inquiries and responses.
- Claims status inquiries and responses.
- Authorization requests and responses.
- Remittance advices.

Molina is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers should refer to Molina's website at MolinaHealthcare.com for additional information regarding HIPAA standard transactions.

1. Click on the area titled "I'm a Health Care Professional."
2. Click the tab titled "HIPAA."
3. Click on the tab titled "HIPAA Transactions" or "HIPAA Code Sets."

Code Sets

HIPAA regulations require that only approved code sets may be used in standard electronic transactions. For claims with dates of service prior to October 1, 2015, ICD-9 coding must be used. For claims with dates of service on or after October 1, 2015, Providers must use the ICD-10 code sets.

National Provider Identifier (NPI)

Provider must comply with the National Provider Identifier (NPI) rule promulgated under HIPAA. The Provider must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to Molina and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within 30 days and should also be reported to Molina within 30 days of the change. Providers must use their NPI to identify it on all electronic transactions required under HIPAA and on all claims and encounters submitted to Molina.

Additional Requirements for Delegated Providers

Providers that are delegated for claims and Utilization Management activities are the "business associates" of Molina. Under HIPAA, Molina must obtain contractual assurances from all business associates that they will safeguard Member PHI. Delegated Providers must agree to various contractual provisions required under HIPAA's Privacy and Security rules.

Reimbursement for Copies of PHI

Molina does not reimburse Providers for copies of PHI related to our Members. These requests may include, although are not limited to, the following purposes:

- Utilization management.
- Care coordination and/or complex medical care management services.
- Claims review.
- Resolution of an appeal and/grievance.
- Anti-fraud program review.

- Quality of care issues.
- Regulatory audits.
- Risk adjustment.
- Treatment, payment, and/or operation purposes.
- Collection of HEDIS® medical records.

14. Claims and Compensation

Hospital-Acquired Conditions and Present on Admission Program
The Deficit Reduction Act of 2005 (DRA) mandated that Medicare establish a program that would modify reimbursement for fee-for-service beneficiaries when certain conditions occurred as a direct result of a hospital stay that could have been reasonably prevented by the use of evidenced-based guidelines. CMS titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting" (HAC and POA).

The following is a list of CMS Hospital-Acquired Conditions. CMS reduces payment for hospitalizations complicated by these categories of conditions that were not present on admission (POA):

1. Foreign object retained after surgery.
2. Air embolism.
3. Blood incompatibility.
4. Stage III and IV pressure ulcers.
5. Falls and trauma:
    a) Fractures.
    b) Dislocations.
    c) Intracranial injuries.
    d) Crushing injuries.
    e) Burn.
    f) Other injuries.
6. Manifestations of poor glycemic control:
    a) Hypoglycemic coma.
    b) Diabetic ketoacidosis.
    c) Nonketotic hyperosmolar coma.
    d) Secondary diabetes with ketoacidosis.
    e) Secondary diabetes with hyperosmolarity.
7. Catheter-associated Urinary Tract Infection (UTI).
8. Vascular catheter-associated infection.
9. Surgical-site infection following coronary artery bypass graft—mediastinitis.
10. Surgical-site infection following certain orthopedic procedures:
    a) Spine.
    b) Neck.
    c) Shoulder.
    d) Elbow.
11. Surgical-site infection following bariatric surgery procedures for obesity:
    a) Laparoscopic gastric restrictive surgery.
    b) Laparoscopic gastric bypass.
    c) Gastroenterostomy.
12. Surgical-site infection following placement of Cardiac Implantable Electronic Device (CIED).
13. Iatrogenic pneumothorax with venous catheterization.
14. Deep vein thrombosis (DVT)/Pulmonary Embolism (PE) following certain orthopedic procedures:
    a) Total knee replacement.

b) Hip replacement.

What This Means to Providers

- Acute Inpatient Prospective Payment System (IPPS) Hospital claims will be returned with no payment if the POA indicator is coded incorrectly or missing.
- No additional payment will be made on IPPS hospital claims for conditions that are acquired during the patient's hospitalization.

For more information regarding the Medicare HAC/POA Program, including billing requirements, visit the CMS website cms.hhs.gov/HospitalAcqCond/.

Claim Submission

Participating Providers are required to submit claims to Molina with appropriate documentation. Providers must follow the appropriate state and CMS Provider billing guidelines. Providers must utilize electronic billing though a clearinghouse or the Provider Portal whenever possible and use current HIPAA-compliant ANSI X 12N format (e.g., 837I for Institutional claims, 837P for Professional claims, and 837D for Dental claims), and use electronic Payer ID number **20934**. For Members assigned to a delegated medical group/IPA that processes its own claims, please verify the claim submission instructions on the Member's Molina ID card.

Providers must bill Molina for services with the most current CMS-approved diagnostic and procedural coding available as of the date the service was provided—or for inpatient facility claims, the date of discharge.

Required Elements

The following information **must** be included on every claim:

- Member name, date of birth, and Molina Member ID number.
- Member's gender.
- Member's address.
- Date(s) of service.
- Valid International Classification of Diseases diagnosis and procedure codes.
- Valid revenue, CPT, or HCPCS for services or items provided.
- Valid diagnosis pointers.
- Total billed charges.
- Place and type of service code.
- Days or units as applicable.
- Provider Tax Identification Number (TIN).
- Ten-digit National Provider Identifier (NPI).
- Rendering Provider name as applicable.
- Billing/pay-to Provider name and billing address.
- Place of service and type (for facilities).
- Disclosure of any other health benefit plans.
- E-signature.
- Service facility location information.

Inaccurate, incomplete, or untimely submissions and re-submissions may result in denial of the claim.

National Provider Identifier (NPI)
A valid NPI is required on all claim submissions. Providers must report any changes in their NPI or subparts to Molina as soon as possible, not to exceed 30 calendar days from the change.

Electronic Claims Submission
Molina strongly encourages Participating Providers to submit claims electronically, including secondary claims. Electronic claims submission provides significant benefits to the Provider, including:

- Reduces operations costs associated with paper claims (printing, postage, etc.).
- Increases accuracy of data and efficient information delivery.
- Reduces claim delays, since errors can be corrected and resubmitted electronically.
- Eliminates mailing time so claims reach Molina faster.

Molina offers the following electronic claims submission options:

- Submit claims directly to Molina via the Provider Portal.
- Submit claims to Molina via your regular EDI clearinghouse using **Payer ID 20934**.

Provider Portal
The Provider Portal is a no-cost online platform that offers several claims-processing features:

- Submit Professional (CMS-1500) and Institutional (UB-04) claims with attached files.
- Correct/void claims.
- Add attachments to previously submitted claims.
- Check claims status.
- Create and manage claim templates.
- Create and submit a claim appeal with attached files.

Clearinghouse
Molina uses Change Healthcare as its gateway clearinghouse. Change Healthcare has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit claims to their usual clearinghouse.

Molina accepts EDI transactions through our gateway clearinghouse for claims via 837P for Professional and 837I for Institutional. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure that claims are received for processing in a timely manner.

When your claims are filed via a clearinghouse:

- You should receive a 999 acknowledgement from your clearinghouse.
- You should also receive 277CA response file with initial status of the claim from your clearinghouse.
- You should contact your local clearinghouse representative if you experience any problems with your transmission.

EDI Claims Submission Issues

Providers who are experiencing EDI submission issues should work with their clearinghouse to resolve this issue. If the Provider's clearinghouse is unable to resolve, the Provider may call the Molina EDI Customer Service line at **(866) 409-2935** or email us at EDI.Claims@MolinaHealthcare.com for additional support.

Paper Claim Submissions

Participating Providers should submit claims electronically. If electronic claim submission is not possible, you may submit paper claims to the following address:

Molina Healthcare of Illinois, Inc.
P.O. Box 540
Long Beach, CA 90806

Please keep the following in mind when submitting paper claims:

- Paper claims should be submitted on original red-colored CMS-1500 claims forms.
- Paper claims must be printed using black ink.

Coordination of Benefits (COB) and Third-Party Liability (TPL)

COB

Medicaid is the payer of last resort. Private and governmental carriers **must** be billed prior to billing Molina or medical groups/IPAs. Provider shall make reasonable inquiry of Members to learn whether Member has health insurance, benefits, or Covered Services other than from Molina, or is entitled to payment by a third party under any other insurance or plan of any type. Provider shall immediately notify Molina of said entitlement. In the event that Coordination of Benefits occurs, Provider shall be compensated based on the state regulatory COB methodology. Primary carrier payment information is required with the claim submission. Providers can submit claims with attachments, including Explanation of Benefits (EOB) and other required documents, via the Provider Portal. Providers can also submit this information through EDI and paper submissions.

Third-Party Liability (TPL)

Molina is the payer of last resort and will make every effort to determine the appropriate third-party payer for services rendered. Molina may deny claims when third party has been established and will process claims for Covered Services when probable TPL has not been established or third-party benefits are not available to pay a claim. Molina will attempt to recover any third-party resources available to Members and shall maintain records pertaining to TPL collections on behalf of Members for audit and review.

Timely Claim Filing

Provider shall promptly submit to Molina claims for Covered Services rendered to Members. All claims shall be submitted in a form acceptable to and approved by Molina and shall include all medical records pertaining to the claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by Provider to Molina within 180 calendar days after the discharge for inpatient services or the date of service for outpatient services.

If Molina is not the primary payer under Coordination of Benefits or third-party liability, Provider must submit claims to Molina within 90 calendar days after final determination by the primary payer. Except as otherwise provided by law or provided by government program requirements, any claims that are not submitted to Molina within these timelines shall not be eligible for payment, and Provider hereby waives any right to payment.

Reimbursement Guidance and Payment Guidelines
Providers are responsible for submission of accurate claims. Molina requires coding of both diagnoses and procedures for all claims. The required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for diagnoses. For procedures, the Healthcare Common Procedure Coding System Level 1 (CPT codes), Level 2 and 3 (HCPCS codes) are required for professional and outpatient claims. Inpatient hospital claims require International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS). Furthermore, Molina requires that all claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

Molina utilizes a claims adjudication system that encompasses edits and audits that follow state and federal requirements, and administers payment rules based on generally accepted principles of correct coding. These payment rules include, but are not limited to:

- Manuals and Relative Value Unit (RVU) files published by the Centers for Medicare & Medicaid Services (CMS), including:
  - National Correct Coding Initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and Medically Unlikely Edits (MUEs). In the event a state benefit limit is more stringent/restrictive than a federal MUE, Molina will apply the state benefit limit. Furthermore, if a professional organization has a more stringent/restrictive standard than a federal MUE or state benefit limit, the professional organization standard may be used.
  - In the absence of state guidance, Medicare National Coverage Determinations (NCDs).
  - In the absence of state guidance, Medicare Local Coverage Determinations (LCDs).
  - CMS Physician Fee Schedule RVU indicators.
- Current Procedural Technology (CPT) guidance published by the American Medical Association (AMA).
- ICD-10 guidance published by the National Center for Health Statistics.
- State-specific claims reimbursement guidance.
- Other coding guidelines published by industry-recognized resources.
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than state and federal guidelines.
- Molina policies based on the appropriateness of health care and Medical Necessity.
- Payment policies published by Molina.

Telehealth Claims and Billing

Providers must follow CMS guidelines, as well as state-level requirements. All telehealth claims for Molina Members must be submitted to Molina with correct codes for the plan type. Use the telehealth Place of Service (POS) Code 02, which certifies that the service meets the telehealth requirements. By coding and billing a place of service 02 with a covered telehealth procedure code, the Provider is certifying the Member was present at an eligible originating site when the telehealth services were performed. Modifier GQ is required when applicable. Qualifying telehealth units of service for an originating site must be billed with Q3014 for reimbursement of facility fee.

National Correct Coding Initiative (NCCI)

CMS has directed all federal agencies to implement NCCI as policy in support of Section 6507 of the Patient Affordable Care Act of March 23, 2010. Molina Healthcare uses NCCI standard payment methodologies.

NCCI Procedure-to-Procedure edits prevent inappropriate payment of services that should not be bundled or billed together and promote correct coding practices. Based on NCCI Coding Manual and CPT guidelines, some services/procedures performed in conjunction with an Evaluation and Management (E&M) code will bundle into the procedure when performed by same physician, and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures.

NCCI editing also includes Medically Unlikely Edits (MUEs), which prevents payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same Provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

General Coding Requirements

Correct coding is required to properly process claims. Molina requires that all claims be coded in accordance with the HIPAA Transaction Code Set guidelines and follow the guidelines within each code set.

CPT and HCPCS Codes

Codes must be submitted in accordance with the chapter and code-specific guidelines set forth in the current/applicable version of the AMA CPT and HCPCS codebooks. To ensure proper and timely reimbursement, codes must be effective on the Date of Service (DOS) for which the procedure or service was rendered and **not** the date of submission.

Modifiers

Modifiers consist of two (2) alphanumeric characters and are appended to HCPCS/CPT codes to provide additional information about the services rendered. Modifiers may be appended only if the clinical circumstances justify the use of the modifier(s). For example, modifiers may be used to indicate whether a:

- Service or procedure has a professional component.
- Service or procedure has a technical component.

- Service or procedure was performed by more than one physician.
- Unilateral procedure was performed.
- Bilateral procedure was performed.
- Service or procedure was provided more than once.
- Only part of a service was performed.

For a complete listing of modifiers and their appropriate use, consult the AMA CPT and the HCPCS code books.

ICD-10-CM/PCS Codes
Molina utilizes the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and International Classification of Diseases 10th Revision, Procedure Coding System (ICD-10-PCS) billing rules and will deny claims that do not meet Molina's ICD-10 Claim Submission guidelines. To ensure proper and timely reimbursement, codes must be effective on the dates of service (DOS) for which the procedure or service was rendered and **not** the date of submission. Refer to the ICD-10 CM/PCS Official Guidelines for Coding and Reporting on the proper assignment of principal and additional diagnosis codes.

Place of Service (POS) Codes
Place of Service Codes (POS) are two-digit codes placed on health care professional claims (CMS-1500) to indicate the setting in which a service was provided. CMS maintains POS codes used throughout the health care industry. The POS should be indicative of where that specific procedure/service was rendered. If billing multiple lines, each line should indicate the POS for the procedure/service on that line.

Type of Bill
Type of bill is a four-digit alphanumeric code that gives three specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care, also referred to as a "frequency" code. For a complete list of codes, reference the National Uniform Billing Committee's (NUBC) Official UB-04 Data Specifications Manual.

Revenue Codes
Revenue codes are four-digit codes used to identify specific accommodation and/or ancillary charges. Certain revenue codes require CPT/HCPCS codes to be billed. For a complete list of codes, reference the NUBC's Official UB-04 Data Specifications Manual.

Diagnosis Related Group (DRG)
Facilities contracted to use DRG payment methodology submit claims with DRG coding. Claims submitted for payment by DRG must contain the minimum requirements to ensure accurate claim payment.

Molina processes DRG claims through DRG software. If the submitted DRG and system-assigned DRG differ, the Molina-assigned DRG will take precedence. Providers may appeal with medical record documentation to support the ICD-10-CM principal and

secondary diagnoses (if applicable) and/or the ICD-10-PCS procedure codes (if applicable). If the claim cannot be grouped due to insufficient information, it will be denied and returned for lack of sufficient information.

National Drug Code (NDC)
The 11-digit National Drug Code (NDC) number must be reported on all professional and outpatient claims when submitted on the CMS-1500 claim form, UB-04, or its electronic equivalent.

Providers **must** submit claims with both HCPCS and NDC codes with the **exact** NDC that appears on the medication packaging in the "5-4-2 digit" format (i.e., xxxxx-xxxx-xx), as well as the NDC units and descriptors. Claims submitted without the NDC number will be denied.

Coding Sources
Definitions
CPT—Current Procedural Terminology 4th Edition: an American Medical Association (AMA)-maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. It has three types of CPT codes:

- Category I Code—Procedures/services.
- Category II Code—Performance measurement.
- Category III Code—Emerging technology.

HCPCS—HealthCare Common Procedural Coding System: a CMS-maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify procedure, supply, and durable medical-equipment codes furnished by physicians and other health care professionals.

ICD-10-CM—International Classification of Diseases, 10th Revision, Clinical Modification: ICD-10-CM diagnosis codes are maintained by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) within the Department of Health and Human Services (HHS).

ICD-10-PCS—International Classification of Diseases, 10th Revision, Procedure Coding System: used to report procedures for inpatient hospital services.

Corrected Claims
Corrected claims are considered new claims for processing purposes. Corrected claims must be submitted electronically with the appropriate fields completed on the 837I or 837P. The Provider Portal includes functionality to submit corrected Institutional and Professional claims. Corrected claims must include the correct coding to denote if the claim is a replacement of prior claim or corrected claim for an 837I or the correct resubmission code for an 837P and include the original claim number.

Important: Claims submitted without the correct coding will be returned to the Provider for resubmission.

EDI (Clearinghouse) Submission
837P:

- In the 2300 Loop, the CLM segment (claim information) CLM05-3 (claim frequency type code) must indicate one of the following qualifier codes:
  - "1"—ORIGINAL (initial claim).
  - "7"—REPLACEMENT (replacement of prior claim).
  - "8"—VOID (void/cancel of prior claim).
- In the 2300 Loop, the REF *F8 segment (claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN).

837I:

- Bill type for UB claims are billed in loop 2300/CLM05-1. In Bill Type for UB, the "1," "7," or "8" goes in the third digit for "frequency."
- In the 2300 Loop, the REF *F8 segment (claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN).

Timely Claim Processing
Claim processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Molina have agreed in writing to an alternate schedule, Molina will process the claim for service within 30 days after receipt of clean claims.

The receipt date of a claim is the date Molina receives notice of the claim.

Electronic Claim Payment
Participating Providers are **required** to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers who enroll in EFT payments will automatically receive ERAs as well. EFT/ERA services allow Providers to reduce paperwork, provide searchable ERAs, and Providers receive payment and ERA access faster than the paper check and RA processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery. Additional information about EFT/ERA is available at MolinaHealthcare.com or by contacting our Provider Network Management department.

Overpayments and Incorrect Payment Refund Requests
If, as a result of retroactive review of claim payment, Molina determines that it has made an overpayment to a Provider for services rendered to a Member, it will make a claim for such overpayment.

A Provider shall pay a claim for an overpayment made by Molina which the Provider does not contest or dispute within the specified number of days on the refund request letter mailed to the Provider.

If a Provider does not repay or dispute the overpaid amount within the time frame allowed, Molina may offset the overpayment amount(s) against future payments made to the Provider.

Payment of a claim for overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to Molina, or the date that the Provider receives a payment from Molina that reduces or deducts the overpayment.

Claim Disputes/Reconsiderations
Providers disputing a previously adjudicated claim must request such action within 90 days of Molina's original remittance advice date. All request received after this time will be denied for untimely filing.

Molina Providers may use one of the following options for submission of a claim appeal or dispute:

- **Provider Portal**: Providers may submit their appeals and disputes along with supporting documentation through the online Provider Portal. The Portal can be accessed on the Molina Provider home page: Provider Portal.
- **Fax**: A Claims Dispute Request Form is required when submitting via fax. The completed Claims Dispute Request Forms, along with supporting documentation, may be faxed to Molina at **(855) 502-4962**. The Claims Dispute Request Form is on Molina's Provider website: Claims Dispute Request Form.

Note: Requests for adjustments of claims paid by a delegated medical group/IPA must be submitted to the group responsible for payment of the original claim.

The form must be filled out completely in order to be processed.

The Provider will be notified of Molina's decision in writing within 30 days of receipt of the claims dispute/adjustment request.

Balance Billing
The Provider is responsible for verifying eligibility and obtaining approval for those services that require Prior Authorization. Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Molina to the Provider. **Balance billing a Molina Member for Covered Services is prohibited**, other than for the Member's applicable copayment, coinsurance, and deductible amounts. Refer to the Billing section earlier in this Provider Manual.

Fraud and Abuse
Failure to report instances of suspected fraud and abuse is a violation of the law and subject to the penalties provided by law. Please refer to the Compliance section of this Provider Manual for more information.

Encounter Data
Each Provider, capitated Provider, or organization delegated for claims processing is required to submit Encounter Data to Molina for all adjudicated claims. The data is used for many purposes, such as regulatory reporting, rate setting, risk adjustment, hospital rate setting, the Quality Improvement Program, and HEDIS® reporting.

Encounter Data must be submitted at least once per month, and within 30 days from the date of service in order to meet state and CMS encounter submission threshold and

quality measures. Encounter Data must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I: 837I for Institutional, 837P for Professional, and 837D for Dental. Data must be submitted with claims level detail for all non-institutional services provided.

Molina has a comprehensive automated and integrated Encounter Data system capable of supporting all 837 file formats and proprietary formats if needed.

Providers must correct and resubmit any encounters that are rejected (non-HIPAA compliant) or denied by Molina. Encounters must be corrected and resubmitted within 15 days from the rejection/denial.

Molina has created 837P, 837I, and 837D Companion Guides with the specific submission requirements available to Providers.

When encounters are filed electronically Providers should receive two (2) types of responses:

- First, Molina will provide a 999 acknowledgement of the transmission.
- Second, Molina will provide a 277CA response file for each transaction.

15. Credentialing and Recredentialing

Uniform Credentialing and Recredentialing

If the practitioner is not enrolled in IMPACT, practitioner must follow Molina's credentialing and recredentialing process.

In accordance with 42 CFR 438.214, Provider enrollment in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system constitutes Illinois' Medicaid managed care uniform credentialing and recredentialing process. To participate in Molina's Provider Network, Molina must verify that practitioner is enrolled in IMPACT. Molina will submit monthly reports to the Illinois Department of Healthcare and Family Services (HFS) indicating which practitioners have completed the credentialing process and the results of the process.

16. Provider Claim Dispute, Provider Complaint, Enrollee Appeal, and Grievance Process

Provider Claim Dispute Process
A request to review the processing, payment, or non-payment of a claim by Molina shall be classified as a Provider Claim Dispute and can be submitted through one of the following options:

- **Portal**: Providers are strongly encouraged to use the Provider Portal to submit Provider Claim Disputes.
- **Fax**: Provider Claim Disputes can be faxed to Molina at **(855) 502-4962**. They must also contain a completed Claims Dispute Form.

Note: CDs containing medical records may be sent to:
Molina Healthcare of Illinois, Inc.
Attention Provider Disputes
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523.
Provider **must** include a completed Claims Dispute Form.

A contracted Provider may request reconsideration of a claim on his or her behalf by submitting a completed Claims Dispute Form with supporting documentation as appropriate. The Claims Dispute Form must be completed to document the review request. It can be found online at MolinaHealthcare.com under the Forms tab.

All Provider reconsiderations for payment or non-payment must be submitted to Molina within 90 calendar days from the date of original remittance advice. All requests received after this time frame will be denied for untimely filing. An upheld resolution letter will be sent to the Provider.

To dispute timely filing, Providers must submit documentation to support their timely filing. Acceptable documentation of timely filing is a signed receipt by Molina staff for registered postal or commercial delivery system.

Molina will have 60 business days to process a claims-related dispute or reconsideration request. All requests submitted without appropriate documentation will be denied for lack of information. The Provider will be responsible for providing the appropriate requested documentation within 90 calendar days from the original remittance date. Molina or a regulatory agency may request medical records during the reconsideration process; the Provider shall **not** charge the Enrollee or Molina for requested records submitted for the reconsideration.

Provider Complaints
Providers have the right to file a complaint if they are dissatisfied with any aspect of operation or service rendered by Molina that **does not** pertain to a benefit or claim determination. Complaints may be submitted no later than 30 calendar days from the date the Provider becomes aware of the issue generating the complaint. Provider complaints can be sent to Molina at:

Fax: (855) 502-4962

Molina Healthcare of Illinois, Inc.
Attention Provider Complaints Dept.
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523

Enrollee Appeals Processes
Molina Enrollees or the personal representatives of Enrollees have the right to file a grievance and submit an appeal through a formal process. All appeals must first be submitted to Molina within 60 days from the Adverse Benefit Determination. Appeals not resolved wholly in the Enrollee's favor can be appealed to the Illinois Department of Healthcare and Family Services (HFS). However, the filing of an appeal does not preclude the Enrollee from filing a complaint with HFS.

This section addresses the identification, review, and resolution of Enrollee's appeal. Below are Molina's Enrollee Appeals Process:

Appeals may be submitted by Enrollees or an authorized representative, such as a family member or the Provider, on behalf of the Enrollee in response to an Adverse Benefit Determination. If the appeal is submitted by someone other than the Enrollee, a signed Molina Healthcare of Illinois Authorized Representative Designation form must be included with submission. If Molina's decision is to deny a service in whole or part, Enrollees and Providers are notified of the following at the time of denial:

- Their right to appeal the decision.
- The process by which the appeal process is initiated.
- The Molina Member Services phone number, where more information regarding the appeals process can be obtained.
- The availability of the Illinois State Department of Insurance.

Medical Coverage/Member Appeals on Selected Services
Molina has different fax numbers for appeal requests for the following specialized clinical services:

- Imaging and special tests:
  - Advanced imaging (MRI, CT, PET, select ultrasounds).
  - Cardiac imaging.
- Radiation therapy.
- Sleep covered services and related equipment.
- Molecular and genomic testing.

Imaging and special tests: Pre-service appeal **fax (855) 502-5128** and post-service appeal **fax (855) 502-4962**. Radiation and specialized services: Pre-service appeal **fax (855) 502-5128** and post-service appeal **fax (855) 502-4962**. Please refer to the Molina Prior Authorization Code Matrix located on the Frequently Used Forms page of the MolinaHealthcare.com website under Authorization Requests.

Enrollee Types of Appeals
An Enrollee may request an expedited appeal or standard appeal. Appeals may be filed orally or in writing. Appeals are filed in order to request that Molina change an adverse determination for care or services submitted by the Enrollee or their authorized representative. Appeals may be requested within 60 days of the Adverse Benefit Determination notice.

An expedited appeal request is submitted to the plan for review of an Adverse Benefit Determination if the standard appeal time frame indicates such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the individual in (or, with respect to a pregnant woman, the health of the woman or her unborn child) serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Enrollee Authorized Representative
An Enrollee may appoint an authorized representative to act on his/her behalf. The representative may be a guardian, caretaker, relative, health care Provider, or an attorney. Any standard appeals requested on behalf of the Enrollee, must have the written authorization from the Enrollee. If an authorized representative is filing an appeal on behalf of the Enrollee, an Authorized Representative Designation form must be completed, signed by the Enrollee, and submitted with the appeal request. Molina can provide the form as needed.

Molina will ensure that no punitive action is taken against a Provider who acts as an authorized representative on behalf of the Enrollee, or supports an appeal filed by an Enrollee.

Enrollee Standard Appeals Process and Timeline
Standard appeals may be received orally or in writing within 60 calendar days following the date of the notice of action. An oral appeal request may be filed by calling Molina's Customer Service department. However, all oral appeals must be followed up with a written request signed by the Enrollee. Standard appeal requests submitted in writing should be sent to this address or fax number:

Molina Healthcare of Illinois, Inc.
Attention Enrollee Appeals and Grievance
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523

Fax: (855) 502-5128

All appeal requests must include the Enrollee's name, address, Member number, reasons for appealing, and documentation or evidence such as medical records, physician letters, or other important information that explains the reason the service or item is needed. An Authorized Representative Form should be attached to the request when appropriate on behalf of an Enrollee. An appeal request submitted after the 60-

day time frame must provide good cause (such as the Enrollee being seriously ill preventing the ability to file the appeal) in order for Molina to consider the late request.

Upon receipt of an appeal, Molina will notify the party filing the appeal of all information that is required to evaluate the appeal. A written acknowledgement will be sent to the Enrollee.

Molina will render a decision on the appeal within 15 business days after receipt of the written appeal request. Molina will orally notify the following of its decision: the party filing the appeal, the Enrollee or authorized representative of the Enrollee, PCP, and any health care Provider who recommended the service involved in the appeal. Oral notification will be followed up by a written notice of determination.

No one reviewing an appeal may have had any involvement in the initial determination that is the subject of the appeal.

Written notifications of the appeal decision will contain reasons for the determination, including the medical or clinical criteria used to make the determination.

If the Enrollee is dissatisfied with the outcome of an appeal, the Enrollee or authorized representative may request an external independent review for non-waiver services.

Enrollees who are not satisfied with Molina's resolution of any appeal may request a state hearing with the Illinois Department of Healthcare and Family Services (HFS) at the following location if they are part of the HealthChoice of Illinois:

Illinois Department of Healthcare and Family Services
Bureau of Administrative Hearing
69 W. Washington, 4th Floor.
Chicago, IL 60602

Fax: (312) 793-2005
Phone: (855) 418-4421 or **TTY at (800) 526-5812**

HFS may also be contacted online at hfs.illinois.gov

Enrollees who are not satisfied with Molina's resolution of an appeal may request a state hearing with the Illinois Department of Human Services (DHS) at the following location if the Members are part of the Persons with Disabilities, Persons with Traumatic Brain Injury (TBI), or Persons with HIV/AIDS waiver populations contained within HealthChoice of Illinois Service Package II:

Illinois Department of Human Services
Bureau of Fair Hearings
69 W. Washington, 4th Fl.
Chicago, IL 60602

Fax: (312) 793-2005
Phone: (855) 418 4421 or **TTY at (800) 526-5812**

Enrollee Expedited Internal Appeals Process and Timeline
Expedited appeals may be received orally or in writing within 60 days from the date of the notice of action. Any requests submitted in writing should be sent to the address or fax number noted above under the Standard Appeal Process section. Expedited appeal requests on behalf of the Enrollee do not require signed written consent of the Enrollee. A request to expedite an appeal will be considered in situations where applying the standard appeal time frame could seriously jeopardize the Enrollee's life, health, or ability to regain maximum function. An expedited review is not possible when services have already been provided to the Enrollee.

Upon receipt of appeal, Molina will notify the party filing the appeal as soon as possible, and within no more than 24 hours after receipt, of all information that is required to evaluate the appeal.

Molina will render a decision within 24 hours after receiving the required information. If additional information required to make the final appeal determination is not received within 72 hours, a determination will be made with the current information available.

If it is determined the expedited appeal request does not meet expedited criteria, the request will be processed under the standard appeal time frame of 15 business days from the date the request was received.

Molina will orally notify the party filing the appeal, the Enrollee (or designated representative), the Enrollee's PCP, the requesting Provider, and any health care Provider who recommended the service involved in the appeal, of its decision. Oral notification will be followed up by a written notice of determination within two (2) calendar days following the oral notification.

Enrollee External Independent Review
An external independent review may be requested by a non-waiver Enrollee or authorized representative either orally or in writing. If received orally, the request will need to be followed up with a written request.

Requests for external independent review must be submitted within 30 days of receipt of written notification of a denied appeal. Written requests must be accompanied by any information or documentation to support the Enrollee's request for Covered Service or claim for a Covered Service.

Molina will do the following for external independent reviews:
- Molina will forward all medical records and supporting documentation, with a description of the applicable issues, and a statement of Molina's decision along with the criteria used and medical and clinical reasons for the decision to the external independent reviewer. The external independent reviewer will evaluate and analyze the case and render a decision for all standard requests. The decision by the independent review is final. If the reviewer determines the health care service to be medically appropriate, Molina will pay for the service. Molina will notify the requestor orally and in writing of the results of the external independent review.
- The external independent reviewer will not be informed of the identity of the Enrollee.

- The external independent reviewer must be a clinical peer and have no direct affiliation to Molina or financial interest in connection with the case in question.

Enrollee Expedited External Independent Review
A request for an expedited independent review may be made orally or in writing. Molina will review the information and notify the requestor within 24 hours of receipt of the request for information if it meets the criteria for an expedited time frame that a standard time frame could seriously risk the Enrollee's life or health. Molina will ensure all external independent reviews are determined as expeditiously as possible, and no later than 24 hours from receipt of the required information. If additional information is required to make the final appeal determination and it is not received within 72 hours, a determination will be made with the current information available. Molina will notify the requestor orally of the results of the expedited external independent review within 24 hours after receipt of the required information. Written notification will be sent within two (2) calendar days from the date the decision was made.

Enrollee Continuation of Benefits
Enrollees may file for a continuation of benefits on or before the latter of ten (10) days from the Adverse Benefit Determination, or the intended effective date of the proposed Adverse Benefit Determination. Molina will continue the Enrollee's benefits during the appeal process. A Provider serving as the Enrollee's authorized representative for the appeal process **cannot** file for continuation of benefits.

Illinois Department of Healthcare and Family Services (HFS) Review
Enrollees not satisfied with the determination of the initial appeal or the external independent reviewer may request a state hearing. Parties to the review include Molina and the Enrollee (or authorized representative).

Requests for HFS review must be filed within 120 days after the date of the Appeal Decision Letter. The request must be sent to HFS at the following address:

Illinois Department of Healthcare and Family Services
Bureau of Administrative Hearings
69 W. Washington, 4th Fl.
Chicago, IL 60602

Fax: (312) 793-2005
Phone: (855) 418-4421 or **TTY at (800) 526-5812**
Online: hfs.illinois.gov

Second Opinion
If an Enrollee wishes to obtain a second opinion on the care they receive, or plan to receive, for covered health care services, he/she may do so from an in-network Provider at no cost. An Enrollee can call Member Services to learn how to get a second opinion at no cost to the Enrollee. HealthChoice of Illinois **(855) 687-7861**. Members can call **(855) 766- 5462**; TTY: 711, Monday through Friday, 8:00 a.m. to 5:00 p.m., Central Time.

Enrollee Grievance Process
Molina has an organized grievance process to ensure thorough, appropriate, and timely resolution to an Enrollee's grievances. A grievance is an expression of dissatisfaction that may include, but is not limited to:

- Requests for disenrollment.
- Difficulty finding a Provider.
- Unhappy with the Prior Authorization process.
- Services provided by Molina staff or Molina Providers.

If an Enrollee is unhappy with Molina or its Providers, he/she may file a grievance by contacting Member Services or write to us at:

Molina Healthcare of Illinois, Inc.
Attention Appeals and Grievance
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523

Fax: (855) 502- 5128

Enrollees are notified of their grievance rights through various general communications including, but not limited to, the Member Handbook, Evidence of Coverage and Disclosure, Member newsletters, and Molina's website.

Enrollees may identify an individual, including an attorney or Provider, to serve as a personal representative to act on their behalf at any stage during the grievance. If under applicable law, a person has authority to act on behalf of an Enrollee in making decisions related to health care or is a legal representative of the Enrollee, Molina will treat such person as a personal representative. Providers are permitted to submit a grievance on behalf of Enrollee; however, signed consent from the Enrollee is required. Molina will ensure that no punitive action is taken against a Provider who acts as an authorized representative on behalf of the Enrollee or supports a grievance filed by an Enrollee.

When needed, Enrollees are given reasonable assistance in completing forms and taking other procedural steps, including translation services for Enrollees with limited English proficiency or other limitations (e.g., hearing impaired, requiring communication support).

Any grievance or appeal with Potential Quality of Clinical Care is referred to the Quality Improvement (QI) department for documentation and further investigation when appropriate. Additionally, any identified issue related to the privacy and confidentiality of Protected Health Information (PHI) is referred to the Privacy Officer.

Enrollee Grievance Timelines
An Enrollee may file a grievance at any time. Grievances may be submitted by phone or in writing. When submitted by phone to the Member Services team, the phone call will serve as the acknowledgment of the grievance. When submitted in writing, a written acknowledgement of the grievance will be sent to the Enrollee within 48 hours from

receipt. A determination will be made as expeditiously as possible but no later than 90 days from receipt of the grievance. Molina will provide the Enrollee (or designated representative) a notification of outcome.

Reporting
All grievance/appeal data, including practitioner-specific data, is reported quarterly to Member/Provider Satisfaction Committee (MPSC) by the department managers for review and recommendation. A summary of the results is reported to the Executive Quality Improvement Committee (EQIC) quarterly. Annually, a quantitative/qualitative report will be compiled and presented to MPSC and EQIC by the chairman of MPSC to be included in the organization's grand analysis of customer satisfaction and assess opportunities for improvement.

Appeals and grievances will be reported to the state if Illinois quarterly**.**

Record Retention
Molina will maintain all grievance and related appeal documentation on file for a minimum of ten (10) years. In addition to the information documented electronically via the Appeals and Grievances log or maintained in other electronic files, Molina will retain copies of any written documentation submitted by the Provider pertaining to the grievance/appeal process. Provider shall maintain records for a period not less than ten (10) years from the termination of the Model Contract and retained further if the records are under review or audit until the review or audit is complete. Provider shall request and obtain Molina's prior approval for the disposition of records if agreement is continuous.

LTSS Program Appeals, Grievances, and State Hearings
Molina maintains an organized and thorough grievance and appeal process to ensure timely, fair, unbiased. and appropriate resolutions. Molina LTSS Members, or their authorized representatives, have the right to voice a grievance or submit an appeal through a formal process.

Molina ensures that Members have access to the appeal process by providing assistance throughout the whole procedure in a culturally and linguistically appropriate manner, including oral, written, and language assistance if needed. Grievance information is also included in the Member Handbook.

17. Delegation

Delegation is a process that gives another entity the ability to perform specific functions on behalf of Molina. Molina may delegate:

- Medical management.
- Credentialing and recredentialing.
- Sanction monitoring for employees and contracted staff at all levels.
- Claims.
- Complex case management.
- CMS preclusion list monitoring.
- Other clinical and administrative functions.

When Molina delegates any clinical or administrative functions, Molina remains responsible to external regulatory agencies and other entities for the performance of the delegated activities, including functions that may be sub-delegated. To become a delegate, the Provider/Accountable Care Organization (ACO)/vendor must be in compliance with Molina's established delegation criteria and standards. Molina's Delegation Oversight Committee (DOC) or other designated committee must approve all delegation and sub-delegation arrangements. To remain a delegate, the Provider/ACO/vendor must maintain compliance with Molina's standards and best practices.

Delegation Reporting Requirements
Delegated entities contracted with Molina must submit monthly and quarterly reports determined by the function(s) delegated to the identified Molina Delegation Oversight staff within the timeline indicated by Molina.

Corrective Action Plans and Revocation of Delegated Activities
If it is determined that the delegate is out of compliance with Molina's guidelines or regulatory requirements, Molina may require the delegate to develop a corrective action plan designed to bring the delegate into compliance. Molina may also revoke delegated activities if it is determined that the delegate cannot achieve compliance or if Molina determines that this is the best course of action.

If you have additional questions related to delegated functions, please contact your Molina Contract Manager.

[Insert IAMHP attestation forms (2 pages) here when Provider Manual PDF is created: file name **IAMHP Attestation Training Completion Form - Updated 6.1.20.pdf**.]