Provider Manual

(Provider Handbook)

Molina Healthcare of Illinois, Inc.

(Molina Healthcare or Molina)

Dual Options Program

(Medicare-Medicaid Program)

2023

MolinaHealthcare.com

Capitalized words or phrases used in this Provider Manual shall have the meaning set forth in your Agreement with Molina Healthcare. "Molina Healthcare" or "Molina" have the same meaning as "Health Plan" in your Agreement. 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: 9/2023

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

Molina Healthcare of Illinois, Inc.

Provider Manual Addendum—January 2023

Section Title: Provider Responsibilities

Subsection Title: COVID-19 Safety Protocols for Federal Contractors

The following language has been removed due to Executive Order 14042 remaining on hold and not being enforced:

COVID-19 Safety Protocols for Federal Contractors
Ensuring Adequate COVID-19 Safety Protocols for Federal Contractors for Subcontracts Over the Simplified Acquisition Threshold of $250,000.

(a) **Definition**. As used in this clause, "United States or its outlying areas" means:
- (1) The 50 States.
- (2) The District of Columbia.
- (3) The commonwealths of Puerto Rico and the Northern Mariana Islands.
- (4) The territories of American Samoa, Guam, and the United States Virgin Islands.
- (5) The minor outlying islands of Baker Island, Howland Island, Jarvis Island, Johnston Atoll, Kingman Reef, Midway Islands, Navassa Island, Palmyra Atoll, and Wake Atoll.

(b) **Authority**. This clause implements Executive Order 14042, Ensuring Adequate COVID Safety Protocols for Federal Contractors, dated September 9, 2021 (published in the Federal Register on September 14, 2021, 86 FR 50985).

(c) **Compliance**. The Provider, a subcontractor, shall comply with all guidance—including guidance conveyed through Frequently Asked Questions, as amended during the performance of this Agreement—for contractor or subcontractor workplace locations published by the Safer Federal Workforce Task Force (Task Force Guidance) at saferfederalworkforce.gov/contractors.

(d) **Subcontracts**. The Provider shall include the substance of this clause, including this paragraph (d), in subcontracts at any tier that exceed the simplified acquisition threshold, as defined in Federal Acquisition Regulation 2.101 on the date of subcontract award, and are for services, including construction, performed in whole or in part within the United States or its outlying areas.

New and Different for 2023

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

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Medicare-Medicaid Plan (MMP)

Molina Healthcare of Illinois is participating in a multi-year demonstration program between the Centers for Medicare & Medicaid Services (CMS) and the Illinois Department of Healthcare and Family Services (HFS). This is known as the Medicare-Medicaid Alignment Initiative (MMAI) in Illinois. Molina also refers to it as Medicare-Medicaid Plan (MMP) or Dual Options Plan (Duals).This program benefits our Members by providing the convenience of coordinated care with one Primary Care Provider and one ID card.

Molina Healthcare's Medicare-Medicaid Plan (MMP) is called Molina Dual Options.

2. Contact Information

Molina Healthcare of Illinois, Inc.
2001 Butterfield Rd., Suite 750
Downers Grove, IL 60515

Provider Network Management Department

The Provider Network Management department handles inquiries from Providers regarding address and Tax-ID changes, contracting, and training. The department has Provider Network Managers who serve all of Molina's Provider Network. Eligibility verifications can be conducted at your convenience via the Availity Essentials Provider Portal: Provider.MolinaHealthcare.com.

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, pharmacy inquiries, selecting or changing Primary Care Providers (PCPs), and Member complaints. Member Services Representatives are available seven days a week, from 8 a.m. to 8 p.m., Central Time, excluding holidays. Eligibility verifications can be conducted at your convenience via the Availity Essentials Portal: Provider.MolinaHealthcare.com.

Phone	Hearing Impaired (TTY/TDD)
(877) 901-8181 (English & Spanish)	711

Claims Department

Molina strongly encourages Participating Providers to submit claims electronically (via a clearinghouse or the Availity Essentials Provider Portal). To verify the status of your claims, please use the Portal. Claims questions can be submitted through the chat feature of the Availity Essentials Provider portal or by contacting Provider Network Management.

- Access the Availity Essentials Portal: Provider.MolinaHealthcare.com
- EDI Payer ID number **20934**

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

Claims Recovery Department

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

Address	Phone	Fax
Molina Healthcare of Illinois, Inc. PO Box 631264	(866) 642-8999	(855) 260-8740

Address	Phone	Fax
Cincinnati OH, 45263-1264		

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 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

Credentialing Department

The Credentialing department verifies all information on the Provider Application prior to contracting and re-verifies this information every three years or sooner, depending on Molina's Credentialing criteria. The information is then presented to the Professional Review Committee to evaluate a Provider's qualifications to participate in the Molina network.

Phone	Fax	Address
(855) 866-5462	(855) 502-4962	Credentialing Molina Healthcare of Illinois, Inc. 2001 Butterfield Rd., Suite 750 Downers Grove, IL 60515

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 24/7 year-round to assess symptoms and help make good health care decisions.

Nurse Advice Line (HEALTHLINE) 24/7 Year-Round	
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 (HCS) department (formerly Utilization Management) conducts concurrent review on inpatient cases and processes Prior Authorizations/Service Requests. The HCS department also performs Care Management for Members who will benefit from Care Management services. Participating Providers are required to interact with Molina's HCS department electronically whenever possible. Prior Authorizations/Service Requests and status checks can easily be 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 electronic Prior Authorizations/Service Requests submission options:

- Submit requests directly to Molina via the Availity Essentials Provider Portal.
- Submit requests via 278 transactions. See the EDI transaction section of Molina's website for guidance.

Availity Essentials Portal	Phone	PA Fax
Provider.MolinaHealthcare.com	(866) 409-2935	Outpatient Requests (844) 251-1451 Inpatient Requests (844) 834-2152

Health Management Department

Molina's Health Management Programs will be incorporated into the Member's treatment plan to address the Member's health care needs.

Phone	TTY/TDD
(866) 891-2320	711

Behavioral Health

Molina manages all components of covered services for Behavioral Health. For Member Behavioral Health needs, please contact Molina directly. Molina has a Behavioral Health Crisis Line that Members may access 24/7 year-round by calling the Member Services phone number on the back of their Molina ID card.

Phone	TTY/TDD
Member Services (877) 901-8181 (English & Spanish)	711

Pharmacy Department

Prescription drugs are covered through our pharmacy benefit manager CVS Caremark. A list of in-network pharmacies is available on the MolinaHealthcare.com website or by contacting Molina's pharmacy services.

Phone	TTY/TDD
(855) 866-5462	711

Quality Improvement

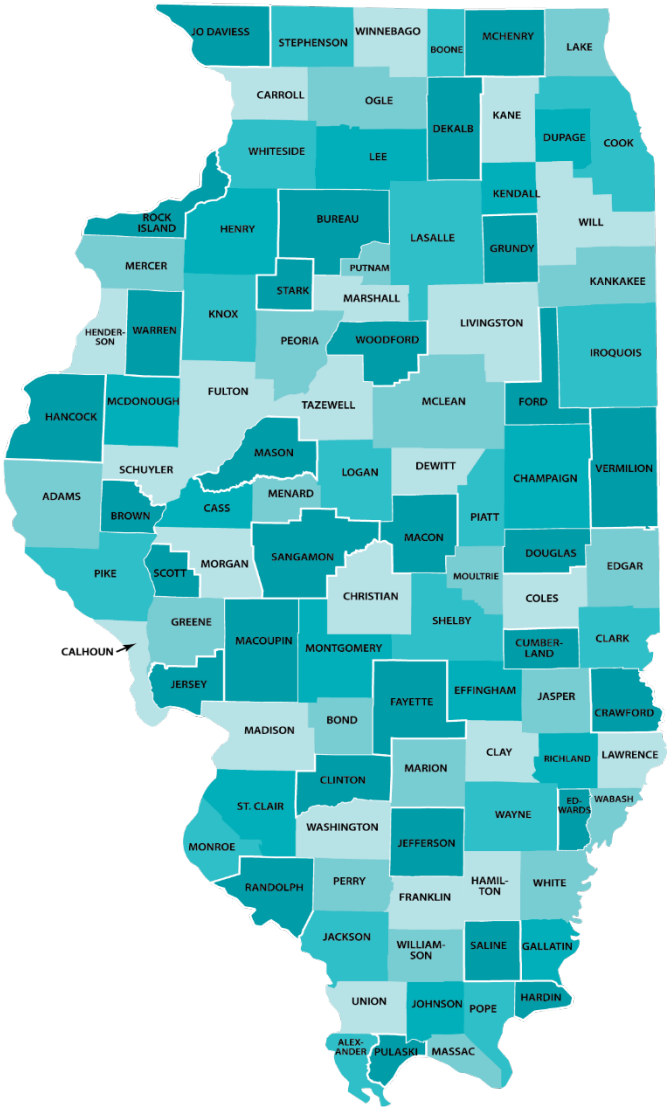
Molina maintains a Quality department to work with Members and Providers in administering

the Molina Quality Program.

Phone	Fax	Email
(855) 866-5462	(855) 556-2074	quality-healthcampaigns@molinahealthcare.com

Molina Healthcare of Illinois, Inc. Service Area

Molina Healthcare of Illinois provides Medicaid HealthChoice, MMAI (MMP Duals), and MLTSS services to all 102 Illinois counties.



3. Eligibility and Enrollment in Dual Options Plans

Enrollment Information

All Members of the Molina Healthcare Dual Options Plan are full-benefit dual eligible (i.e., they receive both Medicare and Medicaid). Centers for Medicare & Medicaid Services (CMS) rules state that these Members may enroll or disenroll throughout the year.

Members who wish to enroll in Medicare Advantage and Dual Options Plans must meet **all of** the following eligibility criteria:

- Have both Medicare Part A and enrolled in Medicare Part B.
- Permanently reside in the geographic service area.
- Member or Member's legal representative completes an enrollment election form completely and accurately.
- Member is fully informed and agrees to abide by the rules of Medicare.
- The Member makes a valid enrollment request that is received by the plan during an election period.
- For Dual Eligible Special Needs Plans, is entitled to Medicaid benefits as defined by the State of Illinois.

Furthermore, Molina does not impose any additional eligibility requirements as a condition of enrollment other than those established by CMS in Chapter 2 of the Medicare Managed Care Manual: cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.

Member Toll-Free Telephone Numbers

Members may call our Member Services department toll free at **(877) 901-8181** from 8 a.m. to 8 p.m. Central Time seven days a week, or TTY/TDD 711 for persons with hearing impairments.

Effective Date of Coverage

Molina will determine the effective date of enrollment for all enrollment requests. The effective date of coverage is determined when the complete enrollment is signed and received, following the Member's enrollment election period.

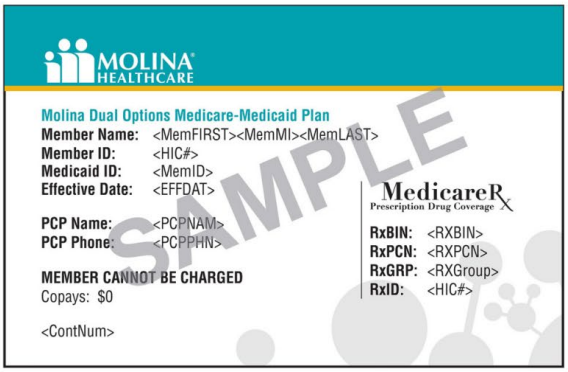
Disenrollment

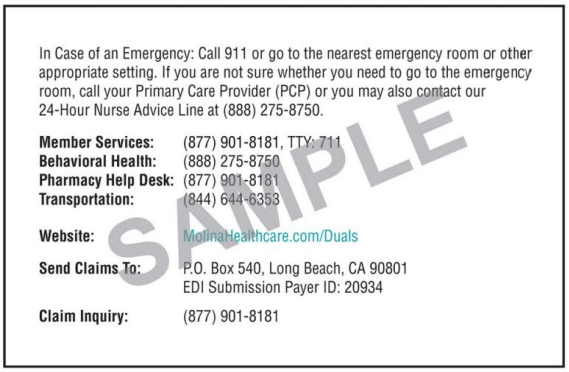
Staff of Molina may never verbally, in writing, or by any other action or inaction, request or encourage a Dual Options Member to disenroll except as outlined in the Molina Evidence of Coverage (EOC). The most current EOC can be found on the Member pages of Molina's website: Information You Need (molinahealthcare.com).

In all circumstances except death, Molina will provide a written notice to the Member with an explanation of the reason for the disenrollment. All notices will be in compliance with CMS regulations and will be approved by CMS.

In the event of death, a verification of disenrollment will be sent to the deceased Member's estate.

Member Identification Card Example—Medical Services





Verifying Eligibility

To ensure payment, Molina strongly encourages Providers to verify eligibility at every visit—and especially prior to providing services that require authorization. Possession of the ID card does not guarantee Member eligibility or coverage. It is the responsibility of the Provider to verify the eligibility of the cardholder.

Providers who contract with Molina may verify a Member's eligibility by checking the following:

- Availity Essentials Provider Portal: provider.MolinaHealthcare.com
- Member Services: **(877) 901-8181**

Cost-Share

Providers can find cost-share information on an individual Molina Member through the Portal at provider.MolinaHealthcare.com or by visiting the Member Materials page of the Molina website.

4. 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 document can be accessed via the following link: molinahealthcare.com/members/il/en-us/mem/duals/resources/info/eoc.aspx.

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 requires 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 Member Services at **(877) 901-8181**, seven days a week, 8 a.m. to 8 p.m., Central Time. TTY/TDD users, please call 711.

Second Opinions

If a Member does not agree with the Provider's plan of care, the Member has the right to request, at no cost, 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.

5. Benefit Overview

Questions about Molina Dual Options Benefits

Please contact Molina's Member & Provider Contact Center toll free with questions as to whether a service is covered or requires Prior Authorization (PA): **(888) 858-2156** seven days a week from 8 a.m. to 8 p.m. Central Time, or TTY/TDD 711 for persons with hearing impairments.

Link to Summary of Benefits, Evidence of Coverage

The following link provides access to the Summary of Benefits and Evidence of Coverage booklets for the Molina Dual Options plan in Illinois: Plan Materials (molinahealthcare.com).

Note: The Medicare-covered Initial Preventive and Physical Examination (IPPE) and the annual wellness visit are covered at zero cost-sharing. Our plans cover Medicare-covered preventive services at no cost to the Member.

Obtaining Access to Certain Covered Services

Telehealth and Telemedicine Services

Molina Members may obtain physical and behavioral health Covered Services from 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.
- Members have the option of receiving PCP services through telehealth. If they choose to use this option, the Member must use a Network Provider who offers telehealth.
- 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 include preventive and/or other routine or consultative visits during a pandemic.
- Services must be coded in accordance with applicable reimbursement policies and billing guidelines.
- Rendering Provider must comply with applicable federal and state guidelines for telehealth service delivery.

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

Supplemental Services

Molina offers supplemental benefits for all Molina Members. Supplemental benefits can be either mandatory, meaning all Members on the plan are eligible for that supplemental benefit, or considered Special Supplemental Benefits for the Chronically Ill (SSBCI). Per CMS, SSBCIs are only available to Members who meet specific criteria by having certain chronic conditions that qualify them for a specific benefit and who have a current, completed Health Risk Assessment (HRA).

A request for SSBCI can be sent directly to Molina's Care Management department which will verify the HRA is current and complete, and validate that the Member has the qualifying diagnosis. Verification of qualifying criteria may require confirmation directly with the Provider, in which a member of our Care Management team will reach out to Provider's office. The Provider can assist by helping with HRA completion. We appreciate your assistance with this process and your support to ensure that all SSBCIs are provided as CMS had intended. Depending on the plan, SSBCI benefits may include:

- Food and produce.
- Service animal supplies allowance.
- Non-Medicare-covered genetic test kits.
- Mental health and wellness applications allowance.
- Pest control.

A referral from the Member's PCP is **not** required for mandatory supplemental benefits. Please refer to the Member Evidence of Coverage (EOC) for more information: Plan Materials (molinahealthcare.com).

Molina partners with Providers/vendors for certain services. To find an in-network Provider/vendor, please refer to the Provider Online Directory (POD) on Molina's website at MolinaHealthcare.com. Molina offers the following supplemental services benefits.

Service	Vendor Name & Address	Telephone
Dental	DentaQuest	(800) 508-6780
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

Provider Education on Covered Benefits and Member Access to Care

Providers are educated on the tools and information required to ensure that Members understand their benefits and how to access care. This includes but is not limited to:

- How to identify Medicare- and Medicaid-covered benefits by accessing the appropriate plan or state agency materials (see link below).
- How to access Medicaid-covered services, including waiver services such as LTSS, IHSS, or Behavioral Services.

Medicaid-Covered Benefits

Medicaid-covered services not covered by MMP/Duals can be found on the State of Illinois' Medicaid website at Applying for Medicaid - Get Care Illinois.

6. Managed Long-Term Services and Support (MLTSS)

MLTSS Overview

MLTSS 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 (CBO) in your area to ensure our Members receive MLTSS services that maintain their independence and ability to remain in the community.

Molina's MLTSS 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 MLTSS Provider Network and achieve a successful partnership in serving those in need.

MLTSS Services and Molina

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.

MLTSS 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—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, or 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 caregiver 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 the 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.

MLTSS 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 Managers will engage with Members and routinely assess for barriers and opportunities to coordinate medical, behavioral health, and MLTSS services. Specifically, along with providing the fully integrated Individualized Plan of Care (IPoC), the Care Manager 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 Manager's name, contact information, and hours of availability are included in the IPoC, which is shared with all Interdisciplinary Care Team (ICT) participants based on a Member's recorded preferences. All Care Managers are required to keep email and voice mail 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:

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

Molina will work closely with the various Community Based Organizations (CBO) 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 MLTSS Members will receive care coordination and be assigned a Care Manager from Molina. The Care Management team for MLTSS will include at a minimum the Member and/or his/her authorized representative, Care Manager, and PCP.

The patient-centered Integrated Care Team (ICT) will include at minimum the Member and/or his/her authorized representative, Care Manager, and anyone a Member requests to participate. ICT Members may also include MLTSS 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 care 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

MLTSS 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 regarding the delivery of these services and supports (42 CFR 441.301).

The 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 Manager.

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 Manager any time, including during the assessment process and through the ICT process. Additional services needed 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 MLTSS service coordination and approvals in the Member's ICP, please contact Molina at **(877) 901-8181**.

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 Managers are trained on the Transitions of Care approach that Molina follows for transitions between care settings.

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, MLTSS Providers, and out-of-network Providers during the COC period. All existing Integrated Care Plans (ICP) 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.
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 MLTSS 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 business days.

For additional information regarding Continuity of Care and transition of MLTSS Members, please contact Molina Member Services at **(877) 901-8181**.

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

Appeals, Grievances, and State Hearings

Molina maintains an organized and thorough grievance and appeal process to ensure timely, fair, unbiased, and appropriate resolutions. Molina MLTSS Members, or their authorized representative(s), 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 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.

Member Grievances

Molina will have a system in place for addressing Member grievances. including grievances regarding reasonable accommodations and access to services under the Americans with Disabilities Act In accordance with Illinois Department of Healthcare and Family Services (HFS). Written records of all grievance activities will be maintained, and Molina will notify HFS of all internal grievances if required.

Members may authorize a designated representative to act on their behalf (hereafter referred to as "representative"). The representative can be a friend, family member, health care Provider, or attorney. An Authorized Representative form can be found on Molina's Member website.

Members may file a grievance by calling Molina's Member Services team at **(877) 901-8181** (TTY for the hearing impaired 711).

Members may also submit a grievance in writing to:

Molina Healthcare of Illinois, Inc.
Attention: Appeals and Grievances Department
2001 Butterfield Rd., Suite 750
Downers Grove, IL 60515

Molina will investigate, resolve, and notify the Member or representative of the findings. Every attempt will be made to resolve a grievance at the time of a call. However, if a grievance is unable to be resolved immediately, it will be resolved as expeditiously as possible, but no later than 90 days from receipt of the grievance.

If the grievance resolution affirms the denial, reduction, suspension, or termination of a Covered Service, or if the resolution permits the billing of a Member due to Molina's denial of payment for that service, Molina will notify the Member of his/her right to request a state hearing.

Member Appeals

Appeals are the request for a review of an action. The Member or the representative acting on behalf of the Member has the right to appeal Molina's decision to deny a service. For Member appeals, Molina must have written consent from the Member authorizing someone else to represent him/her.

All grievances received will be kept confidential, except as needed to resolve the issue and respond to the Member or representative. Additional information on Members' appeals and grievances is available in the Molina Member Handbook.

Members Right to a State Fair Hearing

Members are notified of their right to a state hearing in all of the following situations:

- A service denial (in whole or in part).
- Reduction, suspension, or termination of a previously authorized service.
- A Member is being billed by a Provider due to a denial of payment, and Molina upholds the decision to deny payment to the Provider.

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 the 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.

Critical Incident Reporting and Management

Molina participates in efforts to prevent, detect, and remediate critical incidents, based on requirements for home and community-based waiver programs.

It is important that our Providers report any activities that seem out of the norm. It is imperative that we ensure our Members are protected and safe from harm. Critical incidents that occur in a nursing facility, inpatient behavioral health or Home and Community-Based Service (HCBS) delivery setting (e.g., an adult day health care center, a Member's home, or any other community-based setting), among other settings will be reported in a timely manner.

Providers are **required** to report any occurrence from this list of "incidents" in a timely manner:

- **Abuse**—The infliction (by one's self or others) of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical harm, pain, or mental anguish.
    - Physical abuse is the intentional use of physical force resulting in injury, pain, or impairment. It includes pushing, hitting, slapping, pinching, and other ways of physically

harming a person. It can also mean placing a person in incorrect positions, force-feeding, restraining, or giving medication without knowledge.
    - Emotional abuse occurs when a person is threatened, humiliated, intimidated, or otherwise psychologically hurt. It includes the violation of your right to make decisions and/or the loss of your privacy.
    - Sexual abuse includes rape or other unwanted, nonconsensual sexual contact, but it can also mean forced or coerced nudity, exhibitionism, and other non-touching sexual situations, regardless of the age of the perpetrator.
- **Neglect**—When someone has a duty to do so, but fails to provide goods, services, or treatment necessary to assure a person's health and welfare.
- **Exploitation**—The unlawful or improper act of using a Member or a Member's resources for monetary or personal benefit, profit, or gain.
- **Misappropriation**—Depriving, defrauding, or otherwise obtaining the money or real or personal property (including medication) belonging to a person by any means prohibited by law.
- **Death** of a Member.

The maximum time frame for reporting an incident is 24 hours. The initial report of an incident within 24 hours may be submitted verbally, in which case the person/agency/entity making the initial report shall submit a follow-up written report within 48 hours.

Fighting Fraud, Waste, and Abuse

Proper Member identification is vital to reduce fraud, waste, and abuse (FWA) in government health care programs. The best way to verify a Member's identity is to obtain a copy of the Member's ID card and a form of picture ID. Do you have suspicions of Member or Provider fraud? The Molina AlertLine is available to you 24/7 year-round, even on holidays, at **(866) 606-3889**. Reports are confidential, but you may choose to report anonymously.

Molina complies with all federal and state requirements regarding fraud and abuse, including but not limited to sections 1128, 1156, and 1902(a)(68) of the Social Security Act.

Additional information about fraud, waste, and abuse is available in the Compliance section of this Provider Manual.

Claims for MLTSS Services

Providers are required to bill Molina for all MLTSS waiver services via mail, electronically using EDI submission, or through the Availity Essentials Provider Portal. After registering on the Portal, the Provider will be able to check eligibility and claim status and create/submit claims to Molina. Visit the Provider Portal to register.

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, via the Portal, and by mail. Register for the Portal here: Provider Portal.

For information on how to submit a claim via the Availity Essentials Provider Portal contact the Provider Network Management team at **(855) 866-5462**.

Electronic Visit Verification (EVV)

The purpose of the Electronic Visit Verification (EVV) system is to facilitate proper reimbursement of individual Providers rendering service to MLTSS enrollees receiving their services.

An in-home service Provider agency must do the following regarding the EVV system:

- Adopt internal policies and procedures.
- Provide training resources and technical support for its employees regarding the proper utilization of its EVV systems.
- Provide help desk or call center access for participants and home care aides regarding the delivery of services.

By nature, the EVV system itself must:

- Enable service Provider agencies to obtain real-time data to arrange regular scheduled visits.
- Enable service Provider agencies to respond in a timely manner to missed visits to ensure reliability in the delivery of care.
- Enable the use of the recorded EVV data for billing, verification, automated billing, and improved administrative efficiencies.

An EVV system must meet the following minimum standards:

- Functional capacity.
- Billing integration and data sharing.
- Data storage and security.
- Electronic reporting interface.
- Disaster recovery.

A system is subject to review and audit by the Illinois Department on Aging: illinois.gov/aging/Pages/default.aspx.

The full administration code can be found on the Illinois General Assembly website: ilga.gov/commission/jcar/admincode/089/089002400O15310R.html.

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 a National Provider Identifier (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 (but are not limited to) taxi services, 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.

Atypical Providers are required to use their Medicaid Identification Number given to them by the State of Illinois to take the place of the NPI.

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

Claims Submission: Online Provider Portal

We strongly encourage our MLTSS Providers to utilize the Availity Essentials Provider Portal to submit claims. Please see the Claims and Compensation section of this Provider 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 Filing Processing

Standard timely filing is 365 days for the Dual Options Plan.

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).

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

- Availity Essentials Provider Portal—Providers are strongly encouraged to use the 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, Attention: Provider Disputes, 2001 Butterfield Rd., Suite 750, Downers Grove, IL 60515. Must also include completed Claims Dispute Form.
- **Important**—Please submit only one 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 form 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

Service	Code	Modifier	Unit/Billing Increment	Taxonomy*
Respite Agency Services – LPN	T1005	TE	15 minutes	385H00000X 376J00000X 251E00000X
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

7. 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**.

Mail requests:

Molina Healthcare of Illinois, Inc.
Quality Department
2001 Butterfield Rd., Suite 750
Downers Grove, IL 60515

This Provider Manual contains excerpts from the Molina Quality Improvement Program. For a complete copy of Molina's Quality Improvement Program, 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. 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 Care 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.

The Tax Relief and Health Care Act of 2006 mandates that the Office of Inspector General report to congress regarding the incidence of "Never Events" among Medicare beneficiaries, the payment for services in connection with such events, and the Centers for Medicare & Medicaid Services (CMS) processes to identify events and deny payment.

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 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 hard copy, 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 Molina 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 Advance 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 preventive 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 10 years from the last date of treatment—or for a minor, one year past their 20th birthday, but never less than 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:

- 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 PHI.
- 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. For additional information regarding HIPAA, 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 provided by contracted PCPs and participating specialists. Providers surveyed regarding their appointment availability include OB/GYNs (high-volume specialists), oncologists (high-impact specialists), and Behavioral Health providers. 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 80% availability for Emergency Services and 80% or greater for all other services. The PCP or his/her designee must be available to Members 24/7 year-round.

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 5 weeks from the date of request
Routine Preventive Care for Infant	Within 2 weeks from the date of request
Routine, Symptomatic, but Not Deemed Serious	Within 3 weeks from the date of request
Routine, Symptomatic, Not Deemed Serious, but Requires Medical Attention	Within 7 days 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 3 weeks from the date of request (for complaints not deemed serious)
Specialty Care (High Impact)	Within 3 weeks from the date of request (for complaints not deemed serious)
Urgent Specialty Care	Within 24 hours
Initial Prenatal Visit—First Trimester	Within 2 weeks from the date of request
Initial Prenatal Visit—Second Trimester	Within 1 week from the date of request
Initial Prenatal Visit—Third Trimester	Within 3 days from the date of request

Behavioral Health Appointment Types	Standard
Life-Threatening Emergency	Immediately
Non-Life-Threatening Emergency	Within 6 hours
Urgent Care	Within 48 hours
Initial Routine Care Visit	Within 10 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.

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 backup (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. Voicemail alone after hours is not acceptable.

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 Molina's Quality department.

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 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.

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 patients with physical disabilities.

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 accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour and 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 10 or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, and contracts, evidence of a hazardous waste management system in place.
- 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 (Clinical Laboratory Improvement Amendments) 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 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 Directive 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 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 Directive 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 of Age

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.
- Periodic objective screening for social emotional development using a recognized, standardized tool.
- Perinatal depression for mothers of infants in the most appropriate clinical setting, e.g., at the pediatric, behavioral health or OB-GYN visit.

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. 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-ups to ensure resolution are 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 and Care Management headings 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. Clinical Practice Guidelines are reviewed at least annually and more frequently as needed, when clinical evidence changes and is approved by the Quality Improvement Committee.

Molina Clinical Practice Guidelines include the following:

- Acute Stress.
- Adult Preventive Care.
- Anxiety/Panic Disorder.
- Asthma.
- Attention Deficit Hyperactivity Disorder (ADHD).
- Autism
- Bipolar Disorder.
- Children With Special Health Care Needs.
- Chronic Kidney Disease.
- Chronic Obstructive Pulmonary Disease (COPD).
- Clinical Pharmacy Medication Review.
- Community Reintegration and Support.
- Congestive Heart Failure (CHF).
- Coordination of Community Support and Services for Enrollees In HCBS Waivers.
- Coronary Artery Disease (CAD).
- Dental Services.
- Depression.
- Diabetes.

- Heart Failure in Adults.
- Homelessness/Special Health Care Needs.
- Hypertension.
- Long-Term Care (LTC) Residential Coordination of Services.
- Mental Health.
- Obesity.
- Opioid Management.
- Perinatal Care.
- Pharmacy Services.
- Post-Traumatic Stress Disorder (PTSD).
- Pregnancy Management.
- Prenatal, Obstetrical, Postpartum, and Reproductive Health Care.
- Psychotropic Medication Management.
- Schizophrenia.
- Sickle Cell Disease.
- Smoking Cessation.
- Substance Abuse Treatment.
- Suicide Risk.
- Trauma-Informed Primary Care.

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, electronic Provider bulletins, and other media and are available on the Molina website. Individual Providers or Members may request copies from the Molina Quality department.

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:

- Adult Preventive Services Recommendations.
- Recommendations for Preventive Pediatric Health Care.
- Recommended Adult Immunization Schedule for ages 19 Years or Older, United States, 2021.
- Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2021.

All guidelines are updated at least annually and more frequently, as needed when clinical evidence changes, and 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 Satisfaction Assessment.
- Health Outcomes Survey (HOS).
- 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 at the 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. Reduced Member cost-sharing.

Molina's most recent results can be obtained from the Molina Quality team 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 checkups, 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 their Providers, and 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 Satisfaction Assessment

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

Medicare Health Outcomes Survey (HOS)

The HOS measures Medicare Members' physical and mental health status over a two-year period and categorizes the two-year change scores as better, same, or worse than expected. The goal of the HOS is to gather valid, reliable, clinically meaningful data that can be used to target quality improvement activities and resources, monitor health plan performance, and reward top-performing health plans. Additionally, the HOS is used to inform beneficiaries of their health care choices, advance the science of functional health outcomes measurement, and for quality improvement interventions and strategies.

Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey 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 very 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 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 that were provided.
- Be sure 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 Availity Essentials Provider Portal. Providers will find 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 the Molina Quality department.

HEDIS® and CAHPS® are registered trademarks of the National Committee for Quality Assurance (NCQA).

Merit-Based Incentive Payment System (MIPS)

Under the Medicare Access and CHIP Reauthorization Act (MACRA), CMS implemented the Quality Payment Program Merit-Based Incentive Payment System (MIPS). This is a Quality Payment Program that eligible Providers under original Medicare will participate in and does not impact how Medicare and MMP plans are required to pay. Due to this being a quality program, Providers will not receive a bonus or a withhold for MIPS, unless it is specifically in the agreement you have with Molina. Please contact your Provider Network Manager for other quality programs Molina offers.

8. 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 identify 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 are critical to a Member's quality of care. We encourage Providers to code all diagnoses to the highest specificity, as this will ensure Molina receives adequate resources to provide quality programs to you and our Members.

To constitute 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 Provider visit with a Member. The visit may be face-to-face or telehealth, depending on state or CMS requirements.
- Contain a treatment plan and progress notes.
- Contain the Member's name and date of service.
- Include the Provider's signature and credentials.

Interoperability

Provider agrees to deliver relevant clinical documents—Clinical Document Architecture (CDA) or Continuity of Care Document (CCD) format—at encounter close for Molina members by using one of the automated methods available and supported by the Provider's Electronic Medical Records (EMR), including but not limited to Direct Protocol, Secure File Transfer

Protocol (sFTP), query, or web service interfaces such as Simple Object Access Protocol (SOAP External Data Representation) or Representational State Transfer (REST Fast Healthcare Interoperability Resource). CDA or CCD document should include signed clinical notes or conform with the United States Core Data for Interoperability (USCDI) common data set and Health Level 7 (HL7) Consolidated Clinical Data Architecture (CCDA) standard.

Provider will also enable HL7 v2 Admission/Discharge/Transfer (ADT) feed for all patient events for Molina members to the interoperability vendor designated by Molina.

Provider will participate in Molina's program to communicate clinical information using the Direct Protocol. Direct Protocol is the Health Insurance Portability and Accountability Act (HIPAA)-compliant mechanism for exchanging health care information that is approved by the Office of the National Coordinator for Health Information Technology (ONC).

- If Provider does not have Direct Address, Provider will work with its EMR vendor to set up a Direct Account, which also supports the Centers for Medicare & Medicare Services (CMS) requirement of having Provider's Digital Contact Information added in the National Plan and Provider Enumeration System (NPPES).
- If Provider's EMR does not support the Direct Protocol, Provider will work with Molina's established interoperability partner to get an account established.

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 the Provider Network Management team.

9. 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 Section 1557 of the ACA. As a Provider participating in Molina's Provider Network, you and your staff must also comply with the nondiscrimination provisions and guidance set forth by the Department of Health and Human Services, Office for Civil Rights (HHS-OCR), state law, and federal program rules, including Section 1557 of the ACA.
You are required to do, at a minimum, the following:

1. You **MAY NOT** limit your practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.
2. You **MUST** post in a conspicuous location in your office, a Nondiscrimination Notice. A sample of the Nondiscrimination Notice that you will post can be found in the Evidence of Coverage document on the Member website.
3. You **MUST** post in a conspicuous location in your office, a Tagline Document, that explains how to access non-English language services. A sample of the Tagline Document that you will post can be found in the Evidence of Coverage document on the Member website.
4. If a Molina Member is in need of language assistance services while at your office, and you are a recipient of Federal Financial Assistance, you **MUST** take reasonable steps to

make your services accessible to persons with limited English proficiency (LEP). You can find resources on meeting your LEP obligations at hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html. See also, hhs.gov/civil-rights/for-providers/clearance-medicare-providers/technical-assistance/limited-english-proficiency/index.html.

5. If a Molina Member complains of discrimination, you **MUST** provide them with the following information so that they may file a complaint with Molina's Civil Rights Coordinator or the HHS-OCR:

Civil Rights Coordinator Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802 Phone (866) 606-3889 TTY/TDD, 711 Email civil.rights@MolinaHealthcare.com	Office of Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 Website ocrportal.hhs.gov/ocr/portal/lobby.jsf Complaint Form hhs.gov/ocr/complaints/index.html

If you or a Molina Member needs additional help or more information, call **(800) 368-1019** or TTY/TDD (800) 537-7697.

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 Members, 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, with annual reinforcement training offered through Provider Network Management and/or online/web-based training modules.

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

1. Provider written communication 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.

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 **(877) 901-8181**. 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 Molina Members interpreter services 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 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 Nurse Advice Services for Members 24/7 year-round. 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 **(888) 735-2929**, Spanish **(866) 648-3537** or TTY **(866) 833-4703**. The Nurse Advice Line telephone numbers are also printed on Membership cards.

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.

10. 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, detection, and correction, along with the education of appropriate employees, vendors, Providers, and associates doing business with Molina.

Molina's Special Investigation Unit (SIU) supports the Compliance department in its efforts to prevent, detect, and correct 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

Our mission is to pay claims correctly the first time, and that mission begins with the understanding that we need to proactively detect fraud, waste, and abuse, correct it, and prevent it from reoccurring. Since not all fraud, waste, or abuse can be prevented, Molina employs processes that retrospectively and address fraud, waste, or abuse that may have already occurred. Molina strives to detect, 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 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 payments until compliance is met. Molina will take steps to monitor Molina-contracted Providers to ensure compliance with the law.

Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))

Anti-Kickback Statute (AKS) is a criminal law that prohibits the knowing and willful payment of remuneration to induce or reward patient referrals or the generation of business involving any item or service payable by the federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). In some industries, it is acceptable to reward those who refer business to you. However, in the federal health care programs, paying for referrals is a crime. The statute covers the payers of kickbacks—those who offer or pay remuneration—as well as the recipients of kickbacks—those who solicit or receive remuneration.

Molina conducts all business in compliance with federal and state Anti-Kickback Statutes (AKB) statutes and regulations, and federal and state marketing regulations. Providers are prohibited from engaging in any activities covered under this statute.

What is AKB?

AKB statutes and regulations prohibit paying or receiving anything of value to induce or reward patient referrals or the generation of business involving any item or service payable by federal and state health care programs. The phrase "anything of value" can mean cash, discounts, gifts, excessive compensation, contracts not at fair market value, etc. Examples of prohibited AKB actions include a health care Provider who is compensated based on patient volume, or a Provider who offers remuneration to patients to influence them to use their services.

Under Molina's policies, Providers may not offer, solicit an offer, provide, or receive items of value of any kind that are intended to induce referrals of federal health care program business. Providers must not, directly or indirectly, make or offer items of value to any third party, for the purpose of obtaining, retaining, or directing our business. This includes giving, favors, preferential hiring, or anything of value to any government official.

Marketing Guidelines and Requirements

Providers must conduct all Marketing activities in accordance with the relevant contractual requirements and marketing statutes and regulations, both state and federal.

Under Molina's policies, Marketing means any communication to a Beneficiary who is not enrolled with Molina, that can reasonably be interpreted as intended to influence the Beneficiary to enroll with Molina's Medicaid, Marketplace, or Medicare products. This also includes communications that can be interpreted to influence a Beneficiary to not enroll in or to disenroll from another health plan's products.

Restricted Marketing activities vary from state to state but generally relate to the types and forms of communication that health plans, Providers, and others can have with Members and prospective Members. Examples of such communications include those related to enrolling Members, Member outreach, and other types of communications.

Stark Statute

Similar to the Anti-Kickback Statute, but more narrowly defined and applied. It applies specifically to services **provided only by practitioners**, 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 him/herself 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 state and federal health care programs.

Abuse—Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the state and federal health care programs 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 state and federal health care 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 state and federal health care programs.
- Doctor shopping, which occurs when a Member consults a number of Providers for the purpose of inappropriately obtaining services.
- Falsifying documentation in order 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, which are key in trying to identify fraud, waste, and abuse. If the Claims Examiner suspects fraudulent, abusive, or wasteful billing practices, the billing practice is documented and reported to the SIU through Molina's Compliance AlertLine/reporting depository.

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 audits 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 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 National Correct Coding Initiative (NCCI) files, Local Coverage

Determination/National Coverage Determination (LCD/NCD), 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, in 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/or 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, the 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 (PHI) 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 the Provider refuse to allow access to its 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 year-round. 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
2001 Butterfield Rd., Suite 750
Downers Grove, IL 60515

Phone: (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 CMS:

Phone: (800) 633-4227 – (800) MEDICARE
or
Office of Inspector General
Attn: OIG Hotline Operations
PO Box 23489
Washington, DC 20026

Phone: (800) 447-8477
TTY/TDD: (800) 377-4950
Fax (10 page max): (800) 223-8164

Health and Human Services Office of the Inspector General

Online: oig.hhs.gov/fraud/report-fraud/index.asp

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

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

Illinois Attorney General

Online at: hfs.illinois.gov/oig/reportfraud.html

HIPAA (Health Insurance Portability and Accountability Act) Requirements

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 situations.

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 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 (SUD) 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 SUD treatment or programs are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects SUD information, the Federal Confidentiality of SUD 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

[1]See, Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule.
[2] See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

agrees to provide an attestation of return or destruction and nondisclosure 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:

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 must 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. Providers must use the ICD-10 code sets.

National Provider Identifier (NPI)

Providers 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.

Business Continuity Plan (BCP)

The Provider will have a documented Business Continuity Plan (BCP) to ensure continuation and recovery of services after a disruption occurs. The BCP will be updated at least annually and approved by Molina's senior leadership.

The Provider BCP will include:

- Names and contact information for staff responsible for invoking and managing response and recovery.
- Molina notification names and contact information.
- Disaster declaration process.
- Details of how the services will be recovered and restored.
- Details of how the systems and applications supporting the services will be recovered and restored, including recovery of data.

The Provider will notify Molina of a disruption in the services or activation of a BCP within two hours of occurrence, and will provide Molina with regular updates on the situation and actions taken to resolve the issue until normal services have been resumed.

The Provider will ensure that its third parties needed to deliver the services have appropriate BCPs in place to prevent significant disruption to the services.

The Provider will test the BCP at least annually and document the test results. Upon request, the Provider will make available to Molina the results of the most recent test, including lessons learned and remediation plans.

The Provider will participate in Molina's annual tests upon notification and mutual agreement.

After disruption to services, once normal service has been resumed, the Provider will promptly complete a root cause analysis report and provide it to Molina.

Definitions

- **Business Continuity Plan**—Documented procedures that guide organizations to respond, recover, resume, and restore to a pre-defined level of operations following a disruption.
- **Disaster Recovery Plan**—A document that defines the resources, actions, tasks, and data required to manage the technology recovery effort.
- **Disaster Declaration**—Criteria to declare a disaster and appoint the staff authorized to invoke recovery plans to recover and restore services.

Cybersecurity Requirements

Note: The Cybersecurity Requirements section is only applicable to Providers that are delegated Providers that have been delegated by Molina to perform a health plan function.

1. Provider shall comply with the following requirements and permit Molina to audit such compliance as required by law or any enforcement agency.
2. Terms are defined as follows:

    I. **Consumer**—An individual who is a state resident, whose Nonpublic Information is in Molina's possession, custody, or control and which Provider maintains, processes, stores, or otherwise has access to such Nonpublic Information.

    II. **Cybersecurity Event**—Any act or attempt, successful or to the extent known by Provider unsuccessful, to gain unauthorized access to, disrupt, or misuse an Information System or Nonpublic Information stored on such Information System. The ongoing existence and occurrence of attempted but Unsuccessful Security Incidents shall not constitute a Cybersecurity Event under this definition.

    III. **Unsuccessful Security Incidents**—Activities such as pings and other broadcast attacks on Provider's firewall, port scans, unsuccessful log-on attempts, denials of service, and any combination of the above, so long as no such incident results in unauthorized access, use, or disclosure of Molina Nonpublic Information or sustained interruption of service obligations to Molina.

    IV. **Information System(s)**—A discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination, or disposition of electronic Nonpublic Information, as well as any specialized system such as industrial or process controls systems, telephone switching and private branch exchange systems, and environmental control systems.

    V. **Nonpublic Information**—Information that is not publicly available information and is one of the following:

        (a) Business-related information of Molina, the tampering with which or unauthorized disclosure, access, or use of which, would cause a material adverse impact to the business, operations, or security of Molina.

(b) Any information concerning a Consumer that, because of the name, number, personal mark, or other identifier contained in the information, can be used to identify such Consumer, in combination with any one or more of the following data elements:
  (i) Social Security number.
  (ii) Driver's license number, commercial driver's license number, or state identification card number.
  (iii) Account number, or credit or debit card number.
  (iv) Security code, access code, or password that would permit access to a Consumer's financial account.
  (v) Biometric records.

(c) Any information or data, except age or gender, in any form or medium created by or derived from a health care provider or a Consumer, that can be used to identify a particular Consumer, and that relates to any of the following:
  (i) The past, present, or future physical, mental, or behavioral health or condition of a Consumer or a member of the Consumer's family.
  (ii) The provision of health care to a Consumer.
  (iii) Payment for the provision of health care to a Consumer.

VI. **State**—The State of Illinois.

3. Provider shall implement appropriate administrative, technical, and physical measures to protect and secure the information systems and Nonpublic Information, as defined herein, that are accessible to or held by the Provider. Implementation of the foregoing measures shall incorporate guidance issued by the Illinois Department of Insurance, as appropriate.
4. Provider agrees to comply with all applicable laws governing Cybersecurity Events. Molina will decide on notification to affected Consumers or government entities, except where Provider is solely responsible and required by law to notify such Consumers or government entities. Upon Molina's written request, Provider agrees to assume responsibility for informing all such Consumers in accordance with applicable law.
5. In the event of a Cybersecurity Event, Provider shall notify Molina's Chief Information Security Officer of such event by telephone **and** email (provided below) as promptly as possible, but no later than 24 hours from the determination that a Cybersecurity Event has occurred. In addition to the foregoing, Provider shall notify Molina's Chief Information Security Officer (by telephone and email) within 24 hours following payment of a ransom that involves or may involve Molina Nonpublic Information.

Notification to Molina's Chief Information Security Officer shall be provided to:

Molina Chief Information Security Officer
Phone: (844) 821-1942
Email: CyberIncidentReporting@molinahealthcare.com

A follow-up notification shall be provided by mail to:

Molina Chief Information Security Officer
Molina Healthcare, Inc.
200 Oceangate Blvd., Suite 100
Long Beach, CA 90802

6. Upon Provider's notification to Molina of a determination of a Cybersecurity Event, Provider must promptly provide Molina any documentation required and requested by Molina to complete an investigation or, upon written request by Molina, Provider shall complete an investigation pursuant to the following requirements:
   (a) Determine whether a Cybersecurity Event occurred.
   (b) Assess the nature and scope of the Cybersecurity Event.
   (c) Identify Nonpublic Information that may have been involved in the Cybersecurity Event.
   (d) Perform or oversee reasonable measures to restore the security of the Information Systems compromised in the Cybersecurity Event to prevent further unauthorized acquisition, release, or use of the Nonpublic Information.
7. Provider shall maintain records concerning all Cybersecurity Events for a period of at least five (5) years from the date of the Cybersecurity Event, or such longer period as required by applicable laws, and produce those records upon request of Molina.
8. Provider must provide to Molina the following information regarding a Cybersecurity Event in electronic form. Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to Molina concerning the Cybersecurity Event. The information provided to Molina in the initial and subsequent notices must include all of following information known to Provider at the time of the notification:

   (a) The date of the Cybersecurity Event.
   (b) A description of how the information was exposed, lost, stolen, or breached, including the specific roles and responsibilities of Provider, if any.
   (c) How the Cybersecurity Event was discovered.
   (d) Whether any lost, stolen, or breached information has been recovered and, if so, how this was done.
   (e) The identity of the source of the Cybersecurity Event.
   (f) Whether Provider has filed a police report or has notified any regulatory, governmental, or law enforcement agencies and, if so, when such notification was provided to which entities.
   (g) A description of the specific types of information acquired without authorization, which means particular data elements including, for example, types of medical information, types of financial information, or types of information allowing identification of the Consumer.
   (h) The period during which the Information System was compromised by the Cybersecurity Event.
   (i) The number of total Consumers in the state affected by the Cybersecurity Event.

(j) The results of any internal review identifying a lapse in either automated controls or internal procedures, or confirming that all automated controls or internal procedures were followed.

(k) A description of efforts being undertaken to remediate the situation that permitted the Cybersecurity Event to occur.

(l) A copy of Provider's privacy policy and, if requested by Molina, the steps that Provider will take to notify Consumers affected by the Cybersecurity Event.

(m) The name of a contact person who is both familiar with the Cybersecurity Event and authorized to act on behalf of Provider.

9. Provider agrees to fully cooperate with any security risk assessments performed by Molina and/or any designated representative or vendor of Molina. Provider agrees to promptly provide accurate and complete information with respect to such security risk assessments.

In the event that provisions of this section conflict with provisions of any other agreement between Molina and Provider, the stricter of the conflicting provisions will control.

11. Health Care Services (HCS)

Introduction

Health Care Services (HCS) is comprised of Utilization Management (UM) and Care Management (CM) departments that work together to achieve an integrated approach to coordinating care. 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.

Utilization Management (UM)

The Molina Utilization Management program provides pre-service authorization, inpatient authorization management, and concurrent review of inpatient and continuing services. Molina aims to ensure that services are medically necessary and an appropriate use of resources for the Member. Some of the elements of the UM program are:

- Evaluating the medical necessity and appropriateness of health care services across the continuum of care.
- Applying appropriate criteria based on CMS guidelines, third-party guidelines and, when applicable, state requirements.
- Providing pre-admission, admission, and inpatient hospital and skilled nursing facility review.
- Ensuring that services are available in a timely manner, in appropriate settings.
- Ensuring that qualified health care professionals are engaged in the UM decision-making process when appropriate.
- Ensuring the appropriate application of Member benefit coverage and coverage criteria.
- For dual-eligible Members:
    - If Prior Authorization (PA) is submitted to Molina for any non-covered benefits, Molina will inform the Provider in the denial notification which Medicaid insurer, including the contact information, the PA should be submitted to.

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.

MCG Cite for Guideline Transparency and MCG Cite AutoAuth

Molina has partnered with MCG Health to implement Cite for Guideline Transparency. Providers can access this feature through the Availity Essentials Provider Portal. With MCG Cite for Guideline Transparency, Molina can share clinical indications with Providers. The tool operates as a secure extension of Molina's existing MCG resource and helps meet regulations around transparency for delivery of care:

- Transparency—Delivers medical determination transparency.
- Access—Clinical evidence that payers use to support member care decisions.
- Security—Ensures easy and flexible access via secure web access.

MCG Cite for Guideline Transparency does **not** affect the process for notifying Molina of admissions or for seeking Prior Authorization approval. To learn more about MCG or Cite for Guideline Transparency, visit MCG's website or call **(888) 464-4746**.

Molina has also partnered with MCG Health to extend our Cite AutoAuth self-service method for all lines of business to submit advanced imaging prior authorization (PA) requests.

Cite AutoAuth can be accessed via the Availity Essentials Portal and is available 24/7 year-round. This method of submission is **strongly encouraged** as your primary submission route, although fax/phone/email processes are also available. Clinical information submitted with the PA will be reviewed by Molina. This system will provide quicker and more efficient processing of your authorization request, and the status of the authorization will be available immediately upon completion of your submission.

What is Cite AutoAuth and how does it work?

By attaching the relevant care guideline content to each PA request and sending it directly to Molina, health care Providers receive an expedited, often immediate, response. Through a customized rules engine, Cite AutoAuth compares Molina's specific criteria to the clinical information and attached guideline content to the procedure to determine potential for auto authorization.

Self-services available in the Cite AutoAuth tool include, but are not limited to, MRIs, CTs, and PET scans. To see the full list of imaging codes that require PA, refer to the PA code LookUp Tool at MolinaHealthcare.com.

Delegated Utilization Management Functions

Molina may delegate UM functions to qualifying Medical Groups/IPAs and delegated entities. These entities are required to perform these functions 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.

Utilization Management Functions Performed Exclusively by Molina

The following UM functions are conducted by Molina and are **never delegated**:

1. **Transplant**—Molina does not delegate management of transplant cases to the medical group. Providers are required to notify Molina's UM Department (Transplant Unit) when the need for a transplant evaluation is identified. Contracted Providers must obtain Prior Authorization from Molina Medicare for transplant evaluations and surgery. Upon notification, Molina conducts Medical Necessity review. Molina selects the facility to be accessed for the evaluation and possible transplant.
2. **Clinical Trials**—Molina does not delegate to Providers the authority to authorize payment for services associated with clinical trials. See Clinical Trials below for additional information.
3. **Experimental and Investigational Reviews**—Molina does not delegate to Providers the authority to determine and authorize experimental and investigational (E&I) reviews.

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, 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.

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. Medical Necessity decisions are made by a physician or other appropriate licensed health care personnel with sufficient medical expertise and knowledge of the appropriate coverage criteria. These medical professionals conduct medical necessity reviews in accordance with CMS guidelines (such as national and local coverage determinations) and use nationally recognized evidence-based guidelines, third-party guidelines, state guidelines, guidelines from recognized professional societies, and peer-reviewed medical literature, when appropriate. Providers may request to review the criteria used to make the final decision.

Where applicable, Molina Corporate Policies can be found on the public website at MolinaClinicalPolicy.com. Please note that Molina follows federal and state-specific criteria, if available, before applying Molina-specific criteria.

Prior Authorization

Contracted Providers are responsible for requesting Prior Authorization of services when required by Molina policy, which may change from time to time. Failure to obtain Prior Authorization before rendering a service may result in a pre-service denial with Provider liability and/or denial of the claim. The Member **cannot** be billed when a contracted Provider fails to follow the Utilization Management requirements for the Plan, including failure to obtain Prior Authorization before the Member receives the item or service.

Obtaining authorization does not guarantee payment. Molina retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care.

Molina requires Prior Authorization for specified services. The list of services that require Prior Authorization is available in narrative form, along with a more detailed list by CPT and HCPCS codes. Molina Prior Authorization list is normally updated quarterly, and is posted on the Molina website at MolinaHealthcare.com. The Prior Auth LookUp Tool is available on Molina's provider homepage and in the Availity Essentials Provider Portal.

Providers are encouraged to use the Molina Prior Authorization forms located 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 (ordering Provider, servicing Provider, and referring Provider when appropriate).
- Member diagnosis and ICD-10 codes.
- Requested items and/or service/procedure, including all appropriate CPT and HCPCS codes.
- Location where service will be performed (when relevant).
- Supporting clinical information demonstrating Medical Necessity under Medicare guidelines (and/or state guidelines when applicable):
  - Pertinent medical history (treatment, diagnostic tests, examination data).
  - Requested length of stay (for inpatient requests).
  - Rationale for expedited processing.

Members and their authorized representatives may also request Prior Authorization of any item or service they want to receive. In this case, the physician or other appropriate Provider will be contacted to confirm the need for and specific details of the request.

Contracted Providers are expected to cooperate with Molina UM processes and guidelines, including submission of sufficient clinical information to support the medical necessity, level of care, and/or site of service of the items and/or services requested. Contracted Providers must also respond timely and completely to requests for additional information. If Molina determines that a contracted Provider failed to follow the terms and conditions of the relevant Provider Contract or the Provider Manual, a denial may be issued with Provider liability. Members **cannot** be held responsible when the Provider fails to follow the terms and conditions of the relevant Provider Agreement or this Provider Manual. For information on the contracted Provider claims appeals process see the Claims and Compensation section of this Provider Manual.

Requesting Prior Authorization

Notwithstanding any provision in the Provider Agreement that requires 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, refer to the Prior Authorization tools on the MolinaHealthcare.com website:

- Prior Authorization Code LookUp Tool.
- Prior Authorization Code Matrix.
- Prior Authorization Guide.

The most current Prior Authorization guidelines and the Prior Authorization Request Forms can be found on the Molina website at MolinaHealthcare.com.

Requests for Prior Authorization may be made via the Availity Essentials Provider Portal (preferred method), fax, or telephone.

Availity Essentials Provider Portal

Participating Providers are **strongly encouraged** to use the Availity Essentials Provider Portal for Prior Authorization submissions whenever possible. Instructions for how to submit a Prior Authorization request are available on the Portal. The benefits of submitting your Prior Authorization request through the Portal are:

- Create and submit Prior Authorization requests.
- Check status of Prior Authorization requests.
- Receive notification of change in status of Prior Authorization requests.
- Attach medical documentation required for timely medical review and decision-making.

Fax: If the provider is unable to use the Provider Portal, the Prior Authorization Request form can be faxed to Molina at **(866) 617-4971**.

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

- Imaging and special tests:
  - 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.

Providers may also refer to the Prior Authorization Code Matrix (updated quarterly) found on the Frequently Used Forms page at MolinaHealthcare.com for additional information.

Type of PA Request	Fax Number
Advanced Imaging	(877) 731-7218
Radiation and Specialized Services	(844) 251-1451
Behavioral Health	(866) 617-4971
Pharmacy (Part D and Part B drugs and for Medicaid-covered drugs when the Member is in an integrated plan providing Medicaid wrap benefits, such as a FIDE SNP or MMP)	Part D: (866) 290-1309 Part B (J-Codes): (800) 391-6437
Medicare and MMP Hospital Inpatient Admission and Concurrent Review (Medical, Physical Health)	(844) 834-2152
Medicare Prior Authorization (Medical, Physical Health)	(844) 251-1450
For MMP Prior Authorization (Medical, Physical Health)	(844) 251-1451
All other Medicare & MMP requests (Medical, Physical Health)	(866) 617-4971

Phone: Prior Authorizations can be initiated by contacting Molina's Health Care Services department at **(855) 866-5462**. Supporting clinical information should be submitted via fax or the Provider Portal for timely case processing.

Type of PA Request	Phone Number
Advanced Imaging	(877) 731-7218
Behavioral Health	(855) 866-5462
Pharmacy (Part D and Part B drugs and Medicaid-covered drugs when the Member is in an integrated plan providing Medicaid wrap benefits, such as a FIDE SNP or MMP)	(800) 665-3086
All other Medicare & MMP requests (Medical, Physical Health)	(855) 866-5462

Time Frames

Prior Authorization decisions are made as expeditiously as the Member's health condition requires and within regulatory time frames. Medicare organization and coverage determination time frames for pre-service requests are:

Expedited (non-Part B, non-Part D drug)	72 hours – Medicare guidance allows written notice to follow within 3 calendar days after verbal notice to the member**
Expedited Part B drug	24 hours
Expedited Part D drug	24 hours
Standard (non-Part B, non-Part D drug)	14 calendar days
Standard Part B drug	72 hours
Standard Part D drug	72 hours

** Time frames for fully integrated plans such as a FIDE SNP or MMP may vary with regulatory and contractual requirements.

Extensions may be allowed under specific conditions (with the exception of requests involving a Part B or Part D drug).

A Provider may request that a UM decision be expedited if following the standard time frame could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function. Providers must ask that a request be expedited only when this standard is supported by the Member's condition.

Molina's Nurse Advice Line is available to Members and Providers 24/7 year-round at **(888) 275-8750** for English and **(866) 648-3537** for Spanish. Molina's Nurse Advice Line handles urgent and emergent after-hours UM calls. PCPs are notified via fax of all Nurse Advice Line encounters.

Communication of Pre-Service Determinations

Upon approval, the requestor will receive an authorization number. The number may be provided by telephone or fax. When a pre-authorization request is denied with Member liability, the Member is issued a denial notice informing him/her of the decision and the appeal rights, with a copy to the Provider. The Member's appeal rights are discussed further in the Member Grievances and Appeals section of this Provider Manual.

When a pre-authorization request is denied with Provider liability, the Provider is issued a denial notice by fax informing it of the decision. Additional information on the contracted Provider claims appeal process can be found in the Claims Reconsideration subsection located in the Claims and Compensation section of this Provider Manual.

Peer-to-Peer Discussions and Reopenings

Contracted Providers may request a Peer-to-Peer conversation with a Molina Medical Director. Once a final adverse decision is made, however, the decision may not be reversed if Member liability is assigned (i.e., the Member is issued a denial notice with Medicare appeal rights), unless the CMS requirements for a reopening are met. CMS allows MMP plans to use the reopening process only sparingly. Requirements for a reopening include clear clerical error, the procurement of new and material evidence that was not available or known at the time of the decision that may result in a different conclusion, or evidence that was considered in making the decision clearly shows on its face that an obvious error was made at the time of the decision (i.e., the decision was clearly incorrect based on all the evidence presented).

Providers may not use the reopening process for the routine submission of additional information. Reopenings are not allowed once an appeal is filed by the Provider or the Member (or their authorized representative). Molina Medical Directors are available prior to the time of the decision to discuss any unique circumstances to be considered in the case.

Adverse decisions for which only Provider liability is assigned and that do not involve an adverse determination or liability for the member may be subject to a Peer-to-Peer conversation. A Peer-to-Peer conversation is an opportunity to clarify the clinical information or to provide newly discovered clinical information. Molina will not allow contracted Providers to use the Peer-to-Peer process as a vehicle for routine failure to provide sufficient information in the Utilization Management process or to avoid the contracted Provider claims appeals process. Contracted Providers are responsible for providing all information to support the request within the required time frames.

For additional information on the contracted Provider claims appeals process, see the Claims Compensation section of this Provider Manual.

Affirmative Statement About Incentives

All medical decisions are coordinated and rendered by qualified physicians and licensed clinical staff, 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.

All health care professionals involved in the UM decision-making process base decisions 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, and Molina does not receive financial incentives or other types of compensation to encourage decisions that result in underutilization or barriers to care.

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, and other coverage arrangements.

Clinical Trials

National Coverage Determination (NCD) 310.1 provides that Medicare covers the routine costs of qualifying clinical trials (as defined in the NCD), as well as reasonable and necessary items and services used to diagnose and treat complications arising from participation in all clinical trials. All other Medicare rules apply. Routine costs of a clinical trial include all items and services that are otherwise generally available to Medicare beneficiaries that are provided in either the experimental or control arm of a clinical trial except:

- The investigational item or service itself, unless otherwise covered outside of the clinical trial.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct management of the patient.
- Items and services customarily provided by the research sponsors free of charge for any enrollee in the clinical trial.

Routine costs in clinical trials include:

- Items or services that are typically provided absent a clinical trial.
- Items or services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service and, in particular, for the diagnosis or treatment of complications.

For non-covered items and services, including items and services for which Medicare payment is statutorily prohibited, Medicare only covers the treatment of complications arising from the delivery of the non-covered item or service and unrelated to reasonable and necessary care. However, if the item or service is not covered by virtue of a national non-coverage policy (i.e., an NCD) and is the focus of a qualifying clinical trial, the routine costs of the clinical trial will be covered by Medicare but the noncovered item or service itself will not.

Clinical trials must meet qualifying requirements. Additional information on these requirements and the qualifying process can be found in NCD 310.1.

If the Member participates in an unapproved study, the Member will be liable for all costs associated with participation in that study. Members can obtain additional information about coverage for the costs associated with clinical trials and member liability for Medicare cost-sharing amounts in their Evidence of Coverage (EOC) or Member Handbook.

Communication and Availability to Members and Providers

During business hours, HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff at **(855) 866-5462** 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 utilize fax and the Provider Portal for UM access.

Molina's Nurse Advice Line is available to Members and Providers 24/7 year-round at **(888) 275-8750**. Molina's Nurse Advice Line handles urgent and emergent after-hours UM calls. PCPs are notified via fax of all Nurse Advice Line encounters.

Levels of Administrative and Clinical Review

The Molina review process begins with administrative review followed by clinical review if appropriate. Administrative review includes verifying eligibility, appropriate vendor or Participating Provider, and benefit coverage. Clinical review includes Medical Necessity and level of care.

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.

Emergency Services, Urgent Care, and Post-Stabilization Services

Molina covers Emergency Services, as well as Urgently Needed Services and Post-Stabilization Care, for Members in accordance with applicable federal and state law.

Medicare defines Emergency Services as covered services provided to evaluate or treat an Emergency Medical Condition. An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Urgently Needed Services are covered services that:

- Are not Emergency Services but are Medically Necessary and immediately required as a result of an unforeseen illness, injury, or condition.
- Are provided when (1) the Member is temporarily absent from the Plan's service area and, therefore, the Member cannot obtain the needed service from a network provider; or (2) when the Member is in the Plan's service area but the network is temporarily unavailable or inaccessible.
- Given the circumstances, it was not reasonable for the member to wait to obtain the needed services from their regular Plan Provider after returning to the service area or the network becomes available.

Post-Stabilization Care Services are covered services that are:

- Related to an Emergency Medical Condition.
- Provided after the member is stabilized.
- Provided to maintain the stabilized condition or, under certain circumstances, to improve or resolve the member's condition.

Emergency Services and Urgently Needed Services do not require Prior Authorization, although Contracted Provider notification requirements may apply. See Emergency Inpatient Admissions below.

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

Inpatient Admission Notification and Management

Elective Inpatient Admissions

Molina requires Prior Authorization for all elective/scheduled inpatient admissions and procedures to any inpatient facility (i.e., hospitals, SNFs, and other inpatient settings). Contracted SNFs, Long-Term Acute-Care Hospitals (LTACHs), and Acute Inpatient Rehabilitation (AIR) facilities/units must obtain Prior Authorization before admitting the member.

Inpatient facilities are also required to notify Molina of the admission within two business days, or as otherwise specified in the relevant Provider Agreement. Inpatient notifications may be submitted by fax. Contact telephone numbers and fax numbers are provided in the Requesting Prior Authorization section of this Provider Manual.

Continued stay must be supported by clinical documentation supporting the level of care. Failure to obtain Prior Authorization, to provide timely notice of admission, or to support the level of care may result in denial with Provider liability. Members cannot be held liable for failure of a Contracted Provider to follow the terms of the relevant Provider Agreement and this Provider Manual.

For additional information on the contracted Provider Claims appeal process see, the Claims and Compensation section of this Provider Manual.

Emergent Inpatient Admissions

Molina requires notification of all emergent inpatient admissions within two business days, or as otherwise specified in the relevant Provider Agreement. Notification of admission is required to verify eligibility, authorize care, including Level of Care, and initiate concurrent review and discharge planning. Notification must include Member demographic information, Molina ID number, facility information, date of admission, and clinical information supporting the Level of Care. Notifications may be submitted by fax. Contact telephone numbers and fax numbers are in the Requesting Prior Authorization section of this Provider Manual.

Prior Authorization is not required for an observation level of care. Once the member is stabilized and a request for inpatient admission is made or the observation period expires, Contracted Providers are responsible for supporting an admission level of care. Failure to provide timely notice of admission or to support an admission level of care may result in a clinical level of care denial with Provider liability. Members cannot be held liable for a contracted Provider's failure to follow the terms of the relevant Provider Agreement and this Provider Manual.

Premature and medically complex newborns (NICU): Notify ProgenyHealth's UM team directly of admissions via **secure online fax (888) 817-3624**.

For additional information on the contracted Provider Claims appeal process, see the Claims and Compensation section of this Provider Manual.

Inpatient at Time of Termination of Coverage

Members hospitalized on the day that Member in the Plan terminates are usually covered through discharge. Specific Plan rules and Provider Agreement provisions may apply.

NOTICE Act

Under the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), hospitals (including critical-access hospitals) must deliver the Medicare Outpatient Observation Notice (MOON) to any beneficiary (including a Dual Options enrollee) who receives observation services as an outpatient for more than 24 hours. The MOON is issued to inform the beneficiary that he/she is an outpatient receiving observation services and not a hospital inpatient. The beneficiary is informed that the services are covered under Part B, and that Part B cost-sharing amounts apply. Additional information is provided to the beneficiary with regard to how an observation stay may affect his/her eligibility for a SNF level of care, and that Part B does not cover self-administered drugs.

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. Concurrent review is performed for inpatient stays regardless of setting (i.e., including hospital, SNF, and other inpatient setting), although the cadence and extent of concurrent review may vary depending on the setting and the Member's circumstances. Performing these functions requires timely clinical updates. Molina will request updated clinical records from inpatient facilities at regular intervals during a Member's inpatient stay. Requested clinical updates must be received from the inpatient facility within 24 hours of the request or such other time as may be indicated in the request.

Failure to provide timely clinical updates may result in denial of authorization for the remainder of the inpatient admission, with Provider liability dependent on the circumstances and the terms of the relevant Provider Agreement. Members cannot be held liable for a Contracted Provider's failure to follow the terms of the relevant Provider Agreement or this Provider Manual.

Molina will authorize hospital care as an inpatient when the clinical record supports the Medical Necessity of continued hospital stay. An observation level of care should be provided first when appropriate. Upon discharge, the Provider must provide Molina with a copy of Member's discharge summary, including demographic information, date of discharge, discharge plan and instructions, and disposition.

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 communicates and works closely with hospital discharge planners to determine the most appropriate discharge setting for our Members. The clinical staff reviews Medical Necessity and appropriateness for home health, infusion therapy, Durable Medical Equipment (DME), Skilled Nursing Facility (SNF), and rehabilitative services.

Readmissions

Readmission review is important to ensure that Molina Members are receiving hospital care that is compliant with nationally recognized guidelines, as well as federal and state regulations.

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 (readmission) and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions.

Out-of-Network Providers and Services

Molina maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process. Molina requires Members to receive non-emergency medical care within the participating, contracted network of Providers. Services provided by non-contracted Providers must be prior authorized. Exceptions include Emergency Services and Medically Necessary dialysis services obtained by the Member while outside the service area. See the section on Emergency Services above. When no exception applies, Molina will determine whether contracted Providers within the service area are willing and able to provide the items or services requested for the Member.

Termination of Ongoing Services

Termination of Inpatient Hospital Services

Hospitals are required by CMS regulations to deliver the Important Message from Medicare (IM, Form CMS-10065) to all Medicare beneficiaries (including Dual Options Enrollees) who are hospital inpatients within two calendar days of admission. This requirement is applicable to all hospitals regardless of payment type or specialty. Delivery must be made to the Member or the Member's authorized representative in accordance with CMS guidelines. A follow-up copy of the IM is delivered no more than two calendar days before the planned discharge date.

The IM informs Beneficiaries of their rights as a hospital inpatient, including their right to appeal the decision to discharge. Hospitals must deliver the IM in accordance with CMS guidelines, and must obtain the signature of the Beneficiary or his/her representative and provide a copy at that time. When the Member is no longer meeting criteria for continued

inpatient stay and the hospital has not initiated discharge planning, Molina may require that the hospital issue a follow-up copy of the IM and notify the Member of the discharge date or provide additional clinical information supporting an inpatient level of care. Failure to do so may result in the denial of continued hospital services with Provider liability. The Member **cannot** be held liable for any continued care (aside from any applicable deductibles or copayments) without proper notification that includes Member appeal rights located within the IM and, if the Member exercises the appeal rights, not until noon of the day after the Quality Improvement Organization (QIO) notifies the Member of a determination adverse to the Member.

When the Member exercises appeal rights with the Quality Improvement Organization (QIO), the hospital is required to properly complete and deliver the Detailed Notice of Discharge (DND, Form CMS-10066) to the QIO and the Member as soon as possible, and no later than noon following the day of the QIO's notification to the hospital of the appeal. The hospital is also required to provide all information that the QIO requires to makes its determination. At the Member's request, the hospital must provide to the Member a copy of all information provided to the QIO, including written records of any information provided by telephone. This documentation must be provided to the Member no later than close of business of the first day that the Member makes the request.

The exhaustion of a Member's covered Part A hospital days is not considered to be a discharge for purposes of issuing the IM.

Termination of SNF, CORF, and HHA Services

The Notice of Medicare Non-Coverage (NOMNC) is a statutorily required notice issued to Medicare Beneficiaries to inform them of the termination of ongoing services (discharge) by a SNF (including hospital swing beds providing Part A and Part B services), Comprehensive Outpatient Rehabilitation Facility (CORF) or Home Health Agency (HHA). The NOMNC also provides the Beneficiary with appeal rights for the termination of services. The NOMNC must be delivered to the Member or the Member's authorized representative in accordance with CMS guidelines and at least two days prior to discharge (or the next-to-last time services are furnished in the case of CORF or HHA services).

When Molina makes a determination that the Member's continued services are no longer skilled and discharge is appropriate, a valid NOMNC is sent to the contracted Provider (SNF and CORF) for delivery with a designation of the last covered day. Contracted Providers are responsible for delivering the NOMNC on behalf of Molina to the Member or Member representative, and for obtaining signature(s) in accordance with CMS guidelines. The contracted Provider must provide Molina with a copy of the signed NOMNC. If the Member appeals the discharge to the Quality Improvement Organization (QIO), the contracted Provider must also provide the QIO with a signed copy of the NOMNC and all relevant clinical information. The Member cannot be held liable for any care (aside from any applicable deductibles or copayments) without proper notification that includes the appeal rights included in the NOMNC and, if the Member exercises the appeal rights, not before the appeal process with the QIO is complete. If the QIO's decision is favorable to the Member, the Member cannot

be held liable until a proper NOMNC is issued and the Member is given the appeal rights again. Failure of the contracted Provider to complete the notification timely and in accordance with CMS guidelines, or to provide information timely to the QIO, may result in the assignment of Provider liability. Members cannot be held responsible for the contracted Provider's failure to follow the terms of the relevant Provider Agreement or the Provider Manual.

A NOMNC is not issued in the following instances:

- When services are reduced (e.g., Member is receiving physical therapy and occupational therapy from a Home Health Agency and only the occupational therapy is terminated).
- When the Member moves to a higher level of care (e.g., from home health to SNF).
- When the Member exhausts his/her Medicare benefit.
- When the Member terminates services on his/her own initiative.
- When the Member transfers to another Provider at the same level of care (e.g., a move from one SNF to another while remaining in a Medicare-covered stay).
- When the Provider terminates services for business reasons (e.g., the Member is receiving home health services but has a dangerous animal on the premises).

Coordination of Care and Services

Molina HCS staff members 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 members provide an integrated approach to care needs by assisting Members with identification of resources available, such as community programs, national support groups, appropriate specialists and facilities, as well as 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 efforts are efficient and non-duplicative.

Providers must offer the opportunity to provide assistance to identified Members through:

- Notification of community resources, and local or state-funded agencies.
- Education about alternative care.
- How to obtain care, as appropriate.

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 of time; a Provider that has terminated its contractual agreement can provide continued services to Members undergoing a course of treatment 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 for 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 all Providers involved in a Member's care. This is especially critical between specialists, including Behavioral Health (BH) 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, Neglect, Exploitation, Unexplained Death

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 oneself, or unable to protect oneself 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 also 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 Illinois Child Abuse Hotline (Department of Children and Family Services) 24/7 year-round at **(800) 252-2873** or TTY **(800) 358-5117**. Doing so 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). Doing so 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.

To report suspected abuse, neglect, or financial exploitation of an adult age 60 or older or a person with disabilities age 18 to 59, call the statewide, 24-hour Adult Protective Services Hotline at **(866) 800-1409** or TTY **(888) 206-1327**.

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 who 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.

Primary Care Providers

Molina provides a panel of PCPs to care for its Members. Providers in the specialties of Family Medicine, Internal Medicine, and Obstetrics and Gynecology are eligible to serve as PCPs. Members may choose a PCP or have one selected for them by Molina. Molina's Medicare Members are required to see a PCP who is part of the Molina Medicare network. Molina's Medicare Members may select or change their PCP by contacting Molina's Member & Provider Contact Center.

Specialty Providers

Molina maintains a network of specialty Providers to care for its Members. Referrals from a Molina PCP are required for a Member to receive specialty services; however, no Prior Authorization is required. Members are allowed to directly access in-network women's health specialists for routine and preventive health without a referral for services.

Referrals to specialty care outside the network require Prior Authorization from Molina. Molina will assist in ensuring access for second opinions from in-network and out-of-network providers, as applicable.

Care Management (CM)

The Integrated Care Management (ICM) Program provides care coordination and health education for disease management, as well as identifies and addresses psychosocial barriers to accessing care with the goal of promoting high-quality care that aligns with a Member's individual health care goals. Care Management focuses on the delivery of quality, cost-effective, and appropriate health care services for Members. Members may receive health risk assessments that help identify physical health, behavioral health, medication management problems, and Social Determinants of Health (SDOH) to target high-needs Members who would benefit from more intensive support and education from a Care Manager. Additionally, functional, social support, and health literacy deficits are assessed, as well as safety concerns and caregiver needs.

The role of the Care Manager includes:

- Coordination of quality and cost-effective services.
- Appropriate application of benefits.
- Promotion of early, intensive interventions in the least restrictive setting of the Member's choice.
- Assistance with transitions between care settings and/or Providers.
- Provision of accurate and up-to-date information to Providers regarding completed health assessments and care plans.
- Creation of ICPs, updated as the Member's condition, needs, and/or health status change.
- Facilitation of Interdisciplinary Care Team (ICT) meetings as needed.
- Promotion of utilization of multidisciplinary clinical, behavioral, and rehabilitative services.
- Referral to and coordination of appropriate resources and support services, including but not limited to Long-Term Services & Supports (LTSS).

- Attention to Member preference and satisfaction.
- Attention to the handling of Protected Health Information (PHI) and maintaining confidentiality.
- Provision of ongoing analysis and evaluation of the Member's progress toward ICP adherence.
- Protection of Member rights.
- Promotion of Member responsibility and self-management

Referral to Care Management may be made by any of the following entities:

- Member or Member's designated representative(s).
- Member's Primary Care Provider.
- Specialists.
- Hospital staff.
- Home health staff.
- Molina staff.

12. Behavioral Health

Overview

Molina provides a Behavioral Health benefit for Members. Molina takes an integrated, collaborative approach to behavioral health care, encouraging participation from PCPs, Behavioral Health, and other specialty Providers to ensure "whole person" care. All provisions within the Provider Manual are applicable to medical and Behavioral Health Providers unless otherwise noted in this section.

Utilization Management and Prior Authorization

Behavioral health inpatient and residential services can be requested by submitting a Prior Authorization form or contacting Molina's Prior Authorization team at **(855) 866-5462** Monday through Friday from 8 a.m. to 5 p.m. Central Time (excluding state and federal holidays). Providers requesting authorization after-hours should use the Availity Essentials Provider Portal or fax submission options. Emergency psychiatric services do **not** require Prior Authorization.

All requests for behavioral health services should include the most current version of Diagnostic and Statistical Manual of Mental Disorders (DSM) classification. Molina utilizes standard, generally accepted Medical Necessity criteria for Prior Authorization reviews. Please see the Prior Authorization subsection found in the Health Care Services section of this Provider Manual for additional information.

Access to Behavioral Health Providers and PCPs

Members may be directed to an in-network Behavioral Health Provider by a PCP or by Member self-referral. PCPs are able to screen and assess Members for the detection and treatment of any known or suspected Behavioral Health problems and disorders. PCPs may provide any clinically appropriate Behavioral Health service within the scope of their practice. A formal referral or Prior Authorization is **not** needed for a Member to self-refer, or be referred to a PCP or Behavioral Health Provider.

Behavioral Health Providers may direct a Member to an in-network PCP, or a Member may self-refer. Members may be directed to PCP and specialty care Providers to manage their health care needs. Behavioral Health Providers may identify other health concerns, including physical health concerns, that should be addressed by directing the Member to a PCP.

Care Coordination and Continuity of Care

Discharge Planning

Discharge planning begins upon admission to an inpatient or residential behavioral health facility. Members who were admitted to an inpatient or residential behavioral health setting **must** have an adequate outpatient follow-up appointment scheduled with a Behavioral Health Provider prior to discharge.

Interdisciplinary Care Coordination

In order to provide care for the whole person, Molina emphasizes the importance of collaboration among all Providers on the Member's treatment team. Behavioral Health, Primary Care, and other specialty Providers shall collaborate and coordinate care between each other for the benefit of the Member. Collaboration of the treatment team will increase the communication of valuable clinical information, enhance the Member's experience with service delivery, and create opportunity for optimal health outcomes. Molina's Care Management program may assist in coordinating care and communication among all Providers of a Member's treatment team.

Care Management

Molina's Care Management (CM) team includes licensed nurses and clinicians with behavioral health experience to support Members with mental health and Substance Use Disorder (SUD) needs. Members with high-risk psychiatric, medical, or psychosocial needs may be referred by a Behavioral Health Provider to the CM program.

Referrals to the CM program may be made by contacting Molina at:

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

Additional information on the CM program can be found in the Care Management subsection found in the Health Care Services section of this Provider Manual.

Responsibilities of Behavioral Health Providers

Molina promotes collaboration between Providers, and integration of both physical and behavioral health services in effort to provide quality care coordination to Members. Behavioral Health Providers are expected to provide in-scope, evidence-based mental health and SUD services to Molina Members. Behavioral Health Providers may only provide physical health care services if they are licensed to do so.

Providers shall follow quality standards related to access. Molina provides oversight of Providers to ensure that Members are able to obtain needed health services within the acceptable appointment time frames. Please see the Quality section of this Manual for specific access to appointment details.

Molina Healthcare requires patients in all inpatient hospital settings to be seen by an appropriate physician (MD/DO) or advanced practice nurse every day. Face-to-face visits are preferred; however, telehealth visits may be used under certain circumstances. Refer to the Telehealth section.

- For behavioral health/mental health care, the provider seeing the member daily **must** be a psychiatrist (MD/DO) or a certified mental health nurse practitioner.
- Any inpatient stay that does not have a face-to-face evaluation by an appropriate physician or advanced practice nurse will result in denial of the day the member did not receive this level of care.

All Members receiving inpatient psychiatric services **must** be scheduled for a psychiatric outpatient appointment prior to discharge. The aftercare outpatient appointment **must** include the specific time, date, location, and name of the Provider. This appointment **must** occur within seven (7) days of the discharge date. If a Member misses a behavioral health appointment, the Behavioral Health Provider shall contact the Member within 24 hours of a missed appointment to reschedule.

Behavioral Health Crisis Lines

Molina has a Behavioral Health Crisis Line that may be accessed by Members 24/7 year-round. The Molina Behavioral Health Crisis Line is staffed by behavioral health clinicians to provide urgent crisis intervention, emergent referrals, and/or triage to appropriate supports, resources, and emergency response teams. Members experiencing psychological distress may access the Behavioral Health Crisis Line by calling the 24-Hour Nurse Advice Line as listed on the back of the Molina Member ID card:

(888) 275-8750, or TTY (888) 735-2929 for English
(866) 648-3537, or TTY (866) 833-4703 for Spanish

National Suicide Lifeline

The National Suicide Lifeline is reached by dialing 988. Anyone in need of suicide or mental health crisis support (or anyone worried about someone else), can receive free and confidential support 24/7 year-round by dialing 988 from any phone.

Behavioral Health Toolkit for Providers

Molina has developed an online Behavioral Health Toolkit to provide support with screening, assessment, and diagnosis of common behavioral health conditions, plus access to Behavioral Health HEDIS® Tip Sheets and other evidence-based guidance, and recommendations for coordinating care. The material within this tool kit is applicable to Providers in both primary care and behavioral health settings. The Behavioral Health Toolkit for Providers can be found under the Health Resources tab on the MolinaHealthcare.com Provider website.

13. Provider Responsibilities

Nondiscrimination In Health Care Service Delivery

Providers must comply with the nondiscrimination of health care service delivery requirements as outlined in the Cultural Competency and Linguistic Services section of this Provider Manual.

Additionally, Molina requires Providers to deliver services to Molina Members without regard to source of payment. Specifically, Providers may **not** refuse to serve Molina Members because they receive assistance with cost-sharing from a government-funded program.

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, Inc.
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

For more information, refer to the Health and Human Services (HHS) website: federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority.

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 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 information on file with Molina at least once every 90 days for correctness and completeness. Additionally, in accordance with the terms specified in your Provider Agreement, Providers must notify Molina of any changes as soon as possible, but at minimum 30 calendar days in advance of any changes in any Provider information on file with Molina. Changes include but not limited to:

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

For Provider terminations within an existing clinic/practice, Providers must notify Molina in writing in accordance with the terms specified in your Provider Agreement.

Visit Molina's Provider Online Directory at molina.sapphirethreesixtyfive.com to validate your information. Providers can make updates through the CAQH Portal, or you may submit a full roster that includes the required information above for each health care Provider and/or health care facility in your practice.

Providers unable to make updates through the CAQH portal, or roster process, should contact their Provider Network Manager for assistance. A convenient online form can be found at Molina's Provider website on the Frequently Used Forms page under Contracting & Provider Forms: Provider Information Update Form. Complete the form and contact your Provider Network Manager.

Note: Some changes may impact credentialing. Providers are required to notify Molina of changes to credentialing information in accordance with the requirements outlined in the Credentialing and Recredentialing section of this Provider Manual.

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 supply timely responses to such communications.

National Plan and Provider Enumeration System (NPPES) Data Verification

In addition to the above verification requirements, 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 on the CMS website: 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 Availity Essentials 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 Availity Essentials 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.
- Availity Essentials 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 Availity Essentials Provider Portal.
- 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 high-cost paper claims.

Availity Essentials Provider Portal claims submission includes the ability to:

- Add attachments to claims.
- Submit corrected claims.
- Easily and quickly void claims.
- Check claims status.
- Receive timely notification of a change in status for a particular claim.
- Ability to save incomplete/unsubmitted claims.
- Create/manage 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.

Molina contracts with our payment vendor, Change Healthcare, who has partnered with ECHO Health, Inc. (ECHO) for payment delivery and EFT/835 processing. On this platform you may receive your payment via EFT/ACH, a physical check, or a virtual card.

By default, if you have no payment preferences specified on the ECHO platform, your payments will be issued via Virtual Card. This method may include a fee that is established between you and your merchant agreement and is not charged by Molina or ECHO. You may opt out of this payment preference and request payment be reissued at any time by following the instructions on your Explanation of Payment (EOP) and contacting ECHO Customer Service at **(888) 834-3511** or edi@echohealthinc.com. Once your payment preference has been updated, all payments will go out in the method requested.

If you would like to opt out of receiving a Virtual Card prior to your first payment, you may contact ECHO Customer Service at **(888) 834-3511** or edi@echohealthinc.com and request that your Tax ID for payer Molina Healthcare of Illinois be opted out of Virtual Cards.

Once you have enrolled for electronic payments, you will receive the associated ERAs from ECHO with the **Molina Payer ID 20934**. **Note**: Please ensure that your Practice Management System is updated to accept Payer ID 20934. All generated ERAs will be accessible to download from the ECHO provider portal (providerpayments.com).

ECHO has a Customer Service team available to assist Providers with any website issues or questions. Additionally, changes to the ERA enrollment or ERA distribution can be made by contacting the ECHO Health Customer Service team at **(888) 834-3511**.

Once your account is activated, you will begin receiving all payments through EFT, and you will no longer receive a paper Explanation of Payment (EOP) (i.e., Remittance) through the mail. You will receive 835s (by your selection of routing or via manual download) and can view, print, download, and save historical and new ERAs with a two-year lookback.

Instructions about how to register are available under the EDI/ERA/EFT tab on Molina's website MolinaHealthcare.com.

Availity Essentials Provider Portal

Providers and third-party billers can use the **no-cost** Availity Essentials 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.
  - View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP).
  - 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.
- Download forms and documents.
- Send/receive secure messages to/from Molina.

Balance Billing

Pursuant to law, Members who are dually eligible for Medicare and Medicaid shall **not** be held liable for Medicare Part A and B cost-sharing when the state or another payer is responsible for paying such amounts. 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 Member for Covered Services is prohibited, except for the Member's applicable copayment, coinsurance, and deductible amounts.** Members who are dually eligible for Medicare and Medicaid shall **not** be held liable for Medicare Part A and B cost sharing when the state or another payer such as a Medicaid Managed Care Plan is responsible for paying such 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.

Providers who contract with Molina may verify a Member's eligibility via:

- Availity Essentials Provider Portal: provider.MolinaHealthcare.com.
- Molina Provider Services automated phone system: **(855) 866-5462**.

For additional information, please refer to the Eligibility and Enrollment in Molina Dual Options Plans 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.

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.

Primary Care Provider Responsibilities

A Primary Care Provider (PCP) is required to:

- Serve as the ongoing source of primary and preventive care for Members.
- Assist with coordination of care as appropriate for the Member's health care needs.
- Recommend specialists participating in the Molina Provider Network.
- Triage appropriately.
- Notify Molina of Members who may benefit from Care Management.
- Participate in the development of Care Management treatment plans.

Access to Health Providers and PCPs

Network Providers should have and maintain admitting privileges and, as appropriate, delivery privileges. In lieu of these privileges, the Provider should have a written 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.

When a PCP determines that Medically Necessary services are beyond the scope of the PCP's practice, it is necessary to direct the Member to a specialist or other appropriate heath care Provider. Similarly, it may be necessary for the PCP to consult or obtain services from other in-network specialty health professionals (unless the situation is one involving the delivery of Emergency Services). Information may be exchanged between the PCP and specialist to coordinate care of the patient to ensure continuity of care. Providers are required to document these collaborations with other Providers in the patient's medical record. Documentation must include the specialty, services requested, and diagnosis for which another Provider is being used.

Providers should direct Molina Members to health professionals, hospitals, laboratories, and other facilities and Providers that are contracted and credentialed (if applicable) with Molina (i.e., in-network). In the case of urgent and Emergency Services, Providers may direct Members to an appropriate service including, but not limited to, primary care, urgent care, and hospital Emergency Room. Some circumstances may require an out-of-network Provider. Prior Authorization from Molina is required, except in the case of Emergency Services.

For additional information, 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 Providers 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 Medicare Part D 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 Protected Health Information (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 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 Member Grievances and Appeals 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 Delegated Services Addendum. Please see the Delegation section of this Provider Manual for more information about Molina's delegation requirements and delegation oversight.

14. Claims and Compensation

Payer ID	**20934**
Availity Essentials Provider Portal	provider.MolinaHealthcare.com
Clean Claim Timely Filling	Medicaid 180 Days | MMP Duals 365 Days

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 Availity Essentials 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 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.

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.

Required Elements

Electronic submitters should use the Implementation Guide and Molina Companion Guide for format and code set information when submitting to or receiving files from Molina. In addition to the Implementation Guide and Companion Guide, electronic submitters should use the appropriate state-specific Companion Guides and Provider Manuals. These documents are subject to change as new information is available. Please check the Molina website under EDI tab, "Companion Guides" for regularly updated information regarding Molina's companion guide requirements. Note: Remember to choose Illinois from the drop-down list at the top of the page. In addition to the Molina Companion Guide, it is also necessary to use the Illinois-specific companion guides, which are also available on the website for your convenience.

Electronic Claim submissions will adhere to specifications for submitting medical Claims data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for Compliance SNIP levels 1 to 5.

Inaccurate, incomplete, or untimely submissions and re-submissions may result in denial of the claim. The following information **must** be included on every claim:

- Member's name and date of birth.
- 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) or Atypical Provider Identifier (API).
- Rendering Provider information when different from billing Provider.
- Billing/pay-to Provider name and billing address.
- Place of service and type (for facilities).
- Disclosure of any other health benefit plans.
- National Drug Code (NDC), unit of measure and quantity for medical injectables.
- E-signature.
- Service facility location information.
- Prior Authorization number, if applicable.

Provider and Member data will be verified for accuracy and active status. Provider must validate this data in advance of claims submission. This validation will apply to all Provider data submitted and also applies to atypical and out-of-state Providers.

National Provider Identifier (NPI)

A valid NPI is required on all claim submissions except those from atypical Providers. 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.

EDI (Clearinghouse) Submission

Corrected claim information submitted via EDI submission must follow electronic claim standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic claims are validated for Compliance SNIP levels 1 to 5. The 837 claim format allows you to submit changes to claims that were not included on the original adjudication.

The 837 Implementation Guides refer to the National Uniform Billing Data Element Specifications Loop 2300 CLM05-3 for explanation and usage. In the 837 formats, the codes are called "claim frequency codes." Using the appropriate code, you can indicate that the claim is an adjustment of a previously submitted finalized claim. Use the frequency codes in the table below for claims that were previously adjudicated.

Claim Frequency Code	Description	Action
7	Use to replace an entire Claim.	Molina will adjust the original Claim. The corrections submitted represent a complete replacement of the previously processed Claim.
8	Use to eliminate a previously submitted Claim.	Molina will void the original Claim from records based on request.

When submitting claims noted with claim frequency code 7 or 8, the original claim number must be submitted in Loop 2300 REF02 – Payer Claim Control Number with qualifier F8 in REF01. The original claim number can be obtained from the 835 Electronic Remittance Advice (ERA). Without the original claim number, adjustment requests will generate a compliance error and the claim will reject.

Claim corrections submitted without the appropriate frequency code will deny as a duplicate, and the original claim number will not be adjusted.

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

When submitting paper claims:

- Paper claim submissions are not considered to be "accepted" until received at the appropriate Claims PO Box; claims received outside of the designated PO Box will be returned for appropriate submission.
- Paper claims **must** be submitted on original red-and-white CMS-1500 and CMS-1450 (UB-04) claim forms.
- Paper claims not submitted on the required forms will be rejected and returned. This includes black-and-white forms, copied forms, and any altering to include claims with handwriting.
- Claims must be typed with either 10 or 12 point Times New Roman font, using black ink.
- Link to paper claims submission guidance from CMS: cms.gov/Medicare/Billing/ElectronicBillingEDITrans/1500

Corrected Claim Process

Providers may correct any necessary field of the CMS-1500 and CMS-1450 (UB-04) forms.

Corrected claims are considered new claims for processing purposes. Molina **strongly encourages** Providers to submit corrected claims electronically via EDI clearinghouse or the Provider Portal. **All** corrected claims:

- Must be free of handwritten or stamped verbiage (paper claims).
- Must be submitted on a standard red-colored CMS-1450 (UB-04) or CMS-1500 claim form (paper claims).
- Original claim number must be inserted in field 64 of the CMS-1450 (UB-04) or field 22 of the CMS-1500 of the paper claim, or the applicable 837 transaction loop for submitting corrected claims electronically.
- The appropriate frequency code/resubmission code must also be billed in field 4 of the CMS-1450 (UB-04) and 22 of the CMS-1500.

Note: The frequency/resubmission codes can be found in the NUCC (National Uniform Claim Committee) manual for CMS-1500 claim forms or the UB Editor (Uniform Billing Editor) for CMS-1450 (UB-04) claim forms.

Corrected claims **must** be sent within 180 calendar days from the date of service/date of discharge unless approved for exception by health plan. Corrected claims submission options:

- Submit Corrected Claims directly to Molina via the Availity Provider Portal.
- Submit corrected Claims to Molina via your regular EDI clearinghouse

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:

- The Availity Essentials Provider Portal.
- Submit claims to Molina via your regular EDI clearinghouse using **Payer ID 20934**.

Availity Essentials Provider Portal

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

- Submit Professional (CMS-1500) and Institutional (CMS-1450 [UB-04]) claims with attached files.
- Correct/void claims.
- Add attachments to previously submitted claims.

- Check claims status.
- View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP).
- 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.

If you do not have a clearinghouse, Molina offers additional electronic claims submissions options as shown by logging on to the Availity Essentials Portal.

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 refer to the Molina Companion Guide for information on the response format and messages.
- 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 contact their Provider Network Manager for support.

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

Molina shall coordinate payment for Covered Services in accordance with the terms of a Member's Benefit Plan, applicable state and federal laws, and applicable CMS guidance. If Molina is the secondary payer due to COB, Providers shall bill primary insurers for items and services they provide to a Member before they submit claims for the same items or services to Molina for reimbursement. Molina will adjudicate the claim based upon the primary explanation of benefits (EOB) submitted and pay for covered services up to the secondary liability based upon COB payment guidelines.

If services and payment have been rendered prior to establishing third party liability, an overpayment notification letter will be sent to the Provider requesting a refund including third party policy information required for billing.

Medicaid Coverage for Molina Medicare Members

There are certain benefits that will **not** be covered by Molina Medicare Program but **may** be covered by **fee-for-service Medicaid**. In this case, the Provider should bill Medicaid with a copy of the Molina Medicare remittance advice, and the associated state agency will process the claim accordingly.

After exhausting all other primary coverage benefits, Providers may submit claims to Molina Medicare. A copy of the remittance advice from the primary payer must accompany the claim or the claim will be denied. If the primary insurance paid more than Molina's contracted allowable rate, the claim is considered paid in full and zero dollars will be applied to claim.

Reimbursement Guidance and Payment Guidelines

Providers are responsible for submission of accurate claims. Molina requires coding of both diagnoses and procedures for all claims.

- **For Diagnoses**—The required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for diagnoses.
- **For Services**:
  - **Professional and Outpatient Claims**—The Healthcare Common Procedure Coding System Level 1 (CPT codes), Level 2 and 3 (HCPCS codes).
  - **Inpatient Hospital Claims**—The 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 (MUE). 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 (NCD).
  - In the absence of state guidance, Medicare Local Coverage Determinations (LCD).
  - 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 in accordance with applicable billing guidelines.

Telehealth information can be found in the Practitioners Handbook located on the Illinois Department of Healthcare and Family Services (HFS) website: Chapter 200 Medical Provider Manuals.

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. Molina Healthcare, Inc. 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 the 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 (MUE), which prevent 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. In order 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 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 codebooks.

ICD-10-CM/PCS Codes

Molina utilizes the **International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)** and I**nternational 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 CMS-1450 (UB-04) Data Specifications Manual.

Revenue Codes

Revenue codes are four-digit codes used to identify specific accommodation and/or ancillary charges. There are certain revenue codes that require CPT/HCPCS codes to be billed. For a complete list of codes, reference the NUBC's Official CMS-1450 (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, CMS-1450 (UB-04), or its electronic equivalent.

Providers will need to 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.

Molina Coding Policies and Payment Policies

Frequently requested information on Molina's Coding Policies and Payment Policies is available on the Molina website under the Policies tab. Questions can be directed to your Provider Network Manager.

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 sample gives an estimate of the proportion of claims 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 us, or our 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, we may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Molina reserves the right to recover the full amount paid or due to you.

Timely Claim Processing

A complete claim is a claim that has no defect, impropriety, or lack of any required substantiating documentation as outlined in "Required Elements" above, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

Claims 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 or contracted Medical Group/IPA have agreed in writing to an alternate schedule, Molina will process the claim for service as follows:

- 95% of the monthly volume of non-contracted clean claims are to be adjudicated within 30 calendar days of receipt.
- 95% of the monthly volume of contracted claims are to be adjudicated within 60 calendar days of receipt.
- 95% of the monthly volume of non-clean, non-contracted claims shall be paid or denied within 60 calendar days of receipt.

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 in the Provider Responsibilities chapter of this Provider Manual and is available at MolinaHealthcare.com.

Overpayments and Incorrect Payments 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. Providers will receive an overpayment request letter if the overpayment is identified in accordance with state and CMS guidelines. Providers will be given the option to either:

1. Submit a refund to satisfy overpayment.
2. Submit request to offset from future claim payments.
3. Dispute overpayment findings.

Instructions will be provided on the overpayment notice, and overpayments will be adjusted and reflected in your remittance advice. The letter time frames are Molina standards and may vary depending on applicable state guidelines and contractual terms.

Overpayments related to TPL/COB will contain primary insurer information necessary for rebilling, including the policy number, effective date, term date, and subscriber information. For members with Commercial COB, Molina will provide notice within 270 days from the claim's paid date if the primary insurer is a Commercial plan. A provider may resubmit the claim with an attached primary EOB after submission to the primary payer for payment. Molina will adjudicate the claim and pay or deny the claim in accordance with claim processing guidelines.

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 Reconsideration

Providers requesting a reconsideration of a claim previously adjudicated must request such action within 90 calendar days of Molina's original remittance advice date or longer, as stated in the Provider Agreement (the Provider Agreement would supersede).

Reconsiderations are defined as:

- **Appeal**—Written request for reconsideration of a claim related to a complete denial of payment for services.
- **Dispute**—Written request for reconsideration of the amount paid on a claim after the claim has been adjudicated and payment has been remitted.

All claim reconsiderations **must** be submitted on the Molina Claims Dispute Request form found on Provider website and the Availity Essentials Provider Portal. The form **must** be filled out completely in order to be processed. Additionally, the item(s) being resubmitted should be clearly marked as **reconsideration** and **must** include the following documentation:

- Documentation to support the adjustment.
- A copy of the Authorization form (if applicable).
- The claim number clearly marked on **all** supporting documents.

Note: All appeals and disputes **must** be submitted to Molina through one of the following channels:

- **Provider Portal:** provider.molinahealthcare.com.
- **Fax: (562) 499-0610**

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 Provider will be notified of Molina's decision in writing within 60 calendar days of receipt of the claims reconsideration request.

Note: Corrected claims are to be directed through the original claim's submission process, clearly identified as a corrected claim.

Questions pertaining to claim redetermination requests are to be directed to the Provider Network Management team at **(855) 866-5462**.

Provider Reconsideration of Delegated Claims—Contracted Providers

Providers requesting a reconsideration, correction, or reprocessing of a claim previously adjudicated by an entity that is delegated for claims payment **must** submit their request to the delegated entity responsible for payment of the original claim.

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.

If you would like to find out more information regarding the Medicare HAC/POA Program, including billing requirements, the following CMS site provides further information: cms.hhs.gov/HospitalAcqCond/.

Balance Billing

Pursuant to law, Members who are dually eligible for Medicare and Medicaid shall **not** be held liable for Medicare Part A and B cost-sharing when the state or another payer is responsible for paying such amounts.

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 Member for Covered Services is **prohibited**, except for the Member's applicable copayment, coinsurance, and deductible amounts.

Fraud, Waste, and Abuse

Failure to report instances of suspected fraud, waste, 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 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. Medicare Member Grievances and Appeals

Distinguishing Between Appeals Involving Provider Liability and Appeals Involving Member Liability

All Medicare and MMP Member liability denials are subject to the Member Appeals Terms of this Provider Manual described below. The Member will receive the appropriate denial notice with appeal rights [e.g., Integrated Denial Notice, Notice of Denial of Medicare Prescription Drug Coverage, Important Message from Medicare (IM), Notice of Medicare Non-Coverage (NOMNC), or Explanation of Benefits (EOB) or Explanation of Payment (EOP) indicating there is Member responsibility assigned to a claim processed]. When Member liability is assigned, the Member Appeals process must be followed.

Disputes between Molina and a contracted Provider that do not result in an adverse determination or liability for the Member are subject to the Provider Claim Redetermination provisions located in the Claims and Compensation section of this Provider Manual. Chapter 13 of the Medicare Managed Care Manual specifically states that contracted Providers do not have appeal rights on their own behalf under the Medicare Member Appeals process. Contracted Provider disputes involving plan payment denials are governed by the appeals and dispute resolution provisions of the relevant Provider Agreement.

When Molina determines that a contracted Provider failed to follow the terms and conditions of the relevant Provider Agreement or Provider Manual, either administratively or by not providing the clinical information needed to substantiate the services requested, the contracted Provider is prohibited from billing the Member for the services unless Molina has assigned Member liability and issued the appropriate notice with Member Appeal rights.

Additional information on the contracted Provider Claims Appeal process can be found in the Claim Reconsideration subsection of the Claims and Compensation section of this Provider Manual.

Definition of Key Terms used in the Medicare Member Grievance and Appeal Process

Appeal—Any of the procedures that deal with the review of adverse initial determinations made by the Plan on the health care services or benefits under Part C or D that the Member believes he/she is entitled to receive, including delay in providing, arranging for, or approving the health care services or drug coverage (such that a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug. These appeal procedures include a Plan Reconsideration or Redetermination (also referred to as a Level 1 appeal), a reconsideration by an Independent Review Entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review.

For plans providing integrated Medicare and Medicaid benefits, an appeal includes procedures that deal with the review of adverse initial determinations made by the Plan on the health care

services or benefits under the Member's Medicaid coverage under the Plan. Appeals involving Medicaid-covered services or Medicare-Medicaid overlap services for an MMP may follow procedures that vary from standard Medicare rules.

Authorized Representative—An individual appointed by the Member or authorized under state law to act on behalf of the Member in filing a grievance or appeal. An Authorized Representative has all of the rights and responsibilities of the Member. For Medicare, a Member may be appointed using the CMS Appointment of Representative Form found at cms.hhs.gov/cmsforms/downloads/cms1696.pdf. For Plans providing integrated Medicare and Medicaid benefits (e.g., a FIDE SNP or MMP), Medicaid rules may apply for appointing a Member representative for those services covered under Medicaid.

Beneficiary- and Family-Centered Care Quality Improvement Organization (BFCC-QIO or QIO)—Organizations comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. The BFCC-QIOs review beneficiary complaints about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital Emergency Rooms, Skilled Nursing Facilities (SNF), Home Health Agencies (HHA), Medicare managed care plans, Medicare Part D prescription drug plans, and ambulatory surgical centers. The BFCC-QIOs also review continued stay denials in acute inpatient hospital facilities, as well as coverage terminations in SNFs, HHAs, and Comprehensive Outpatient Rehabilitation Facilities (CORF). In some cases, the BFCC-QIO can provide informal dispute resolution between the health care Provider (e.g., physician, hospital, etc.) and the beneficiary.

Grievance—An expression of dissatisfaction with any aspect of the operations, activities, or behavior of a Medicare or Dual Options Plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, an Appeal. Examples of a grievance include but are not limited to the quality of care, aspects of interpersonal relationships such as rudeness of a Provider or Plan employee, waiting times for an appointment, cleanliness of contracted Provider facilities, failure of the Plan or a contracted Provider to respect the Member's rights under the Plan, involuntary disenrollment, Plan benefit design, the organization or Coverage Determination or Appeals process, the Plan formulary, or the availability of contracted Providers.

The grievance process for MMPs also includes dissatisfaction related to any aspect of the Plan's operations, activities, or behavior, including those related to the provision of Medicaid services under the Plan.

Medicare-Medicaid Plan (MMP)—A Plan participating in a federal demonstration to provide coordinated Medicare and Medicaid benefits for dually eligible individuals. MMPs offer Medicare and Medicaid benefits as a single plan under a three-way contract by and among CMS, the state Medicaid agency, and the health Plan.

Organization Determination—Any determination (an approval or denial) made by a Dual Options Plan or its delegated entity with respect to:

- Payment for temporarily out-of-the-area renal dialysis services, emergency services, post-stabilization care, or urgently needed services. (For more information on these services, see the Emergency Services, Urgent Care, and Post-Stabilization Services subsection located in the Health Care Services section of this Provider Manual.)
- Payment for any other health services furnished by a Provider that the Member believes are covered under Medicare or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Dual Options Plan.
- Refusal to authorize, provide, or pay for services, in whole or in part, including the type or level of services that the Member believes should be furnished or arranged by the Dual Options Plan.
- Reduction or premature discontinuation of a previously ongoing course of treatment.
- Failure of the Dual Options Plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide timely notice of an adverse determination, such that a delay would adversely affect the Member's health.

Medicare Member Liability Appeals

How to File an Appeal

For standard appeals (non-Part-D drug), Members should mail or fax their written appeal to:

Molina Healthcare of Illinois, Inc.
Attn: Grievances and Appeals
P.O. Box 22816
Long Beach, CA 90801-9977

Fax: (562) 499-0610

Expedited Appeal requests can be called in to the Molina Contact Center at **(877) 901-8181**.

A verbal standard appeal may be accepted from Members enrolled in Plans providing integrated Medicare and Medicaid benefits, such as an MMP or FIDE SNP.

Members (and/or their authorized representatives) have 60 days from the date of the denial to file an appeal. This time frame may be extended for good cause.

What to include with the appeal

Members should include their name, contact information, Member ID number, health plan name, reason for appealing, and any evidence the Member wishes to attach. Members may send in supporting medical records, documentation, or other information that explains why Molina should provide or pay for the item or service.

Participating Provider Responsibilities In the Medicare Member Appeals Process

- Appeals should include the Member's name, contact information, Member ID number, health plan name, the reason for appealing, and any evidence to support the request.

- Providers can request expedited or standard pre-service Appeals on behalf of their Members; however, if not requested specifically by the treating physician, an Appointment of Representative (AOR) Form may be required. The form can be found on the CMS website: cms.hhs.gov/cmsforms/downloads/cms1696.pdf.
- Provide all medical records and/or documentation to support the Appeal at that time. Note that if additional information must be requested by Molina, processing of the Appeal may be delayed.
- Expedited Appeals should only be requested if waiting the time frame for a standard Appeal could jeopardize the Member's life, health, or ability to regain maximum function.

Time Frames

Appeal decisions are made as expeditiously as the Member's health condition requires and within regulatory time frames.

Expedited Pre-Service (non-Part B, non-Part D drug)	24 hours after receipt of all required information (72 hours max.)**
Expedited Pre-Service Part B drug	72 hours
Expedited Pre-Service Part D drug	72 hours
Standard Pre-Service (non-Part B, non-Part D drug)	15 **business** days**
Standard Pre-Service Part B drug	7 calendar days
Standard Pre-Service Part D drug	7 calendar days
Standard Post-Service (Part C)	15 **business** days
Standard Post-Service Part D drug	14 calendar days

**Time frames for fully integrated plans such as a FIDE SNP or MMP may vary with regulatory and contractual requirements.

Extensions may be allowed under specific conditions (with the exception of requests involving a Part B or Part D drug).

A Provider may request that a pre-service Appeal be expedited if following the standard time frame could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function. Providers must ask that an Appeal be expedited only when this standard is supported by the Member's condition.

Continuation of Benefits (aka "Aid Continuing")

Members enrolled in a Medicare-Medicaid Plan (MMP) may be entitled to continue benefits pending appeal if authorization for services is terminated or modified before the expiration of the authorization period. This typically occurs with Medicaid-covered services such as personal care services but can be applied to other Medicare (non-Part D) or Medicaid services when the services are terminated or modified before the expiration of the authorization period.

The right to continue benefits is subject to the filing of the appeal and/or providing a written request for continuation of benefits within 10 calendar days of the date of the notice of suspension, termination, or modification of the authorization, whichever is later. The right to request continuation of benefits typically resides with the Member (not the Provider).

If the Member's appeal is upheld by the Plan, notice of the appeal decision will contain any instructions for continuation of benefits pending State Fair Hearing.

Federal and state rules applicable to the specific Plan determine whether recovery of costs applies if the Member receives an adverse decision on Level 1 appeal or at State Fair Hearing.

Further Appeal Rights

If Molina upholds the initial adverse determination in whole or in part for a Part C item or service (including a Part B drug), the Appeal will be forwarded to an Independent Review Entity (IRE). For Part D upholds, the Member must request review by the IRE. The IRE is a CMS contractor independent of Molina. If the IRE upholds the initial adverse determination and the amount in controversy requirements are met, the Member may continue to an additional level of Appeal with an Administrative Law Judge (ALJ) or attorney adjudicator. Additional levels of Appeal are available to the Member if the amount in controversy requirements are met, including appeal to the Medicare Appeals Council (MAC) and federal court.

Members in a Medicare-Medicaid Plan (MMP) have additional appeal rights related to their Medicaid benefits. If Molina upholds an initial adverse determination involving items or services that are or could be covered by Medicaid or Medicare and Medicaid, the Member can request a State Fair Hearing. The Member's notice of the appeal decision will tell them how to file for a State Fair Hearing.

Hospital Discharge Appeals

Hospital discharges are subject to an expedited Member appeal process. Members receive their appeal rights through the delivery of the Important Message from Medicare (IM, Form CMS-10065) by the hospital. For additional information on delivery of the IM, see the Termination of Inpatient Hospital Services subsection located in the Health Care Services section of this Provider Manual.

Members disputing their discharge decision may request an immediate Appeal to the QIO for the service area (Livanta or Kepro). The Member must appeal to the QIO as soon as possible, and no later than the planned discharge date and before the Member leaves the hospital. The QIO will typically respond within one day after receiving all necessary information.

If the QIO agrees with the discharge decision, the Member will be responsible for payment for continued care beginning at noon of the calendar day following the day the QIO provides notice of its decision to the Member. The Member may request a reconsideration from the QIO if he/she remains in the hospital. If the QIO continues to agree with the discharge decision, the Member may appeal to an Administrative Law Judge (ALJ) or attorney adjudicator.

If the QIO disagrees with the discharge decision, the Member is not responsible for any continued care (aside from any applicable deductibles or co-payments) without proper notification that includes their appeal rights located within the IM. The Member will then have an opportunity to appeal that subsequent discharge determination.

If the Member misses the deadline to file an appeal with the QIO and is still in the hospital, the Member (or their Authorized Representative) may request an expedited pre-service appeal with the Plan. In this case, the Member does not have financial protection during the course of the expedited pre-service appeal and may be financially liable for paying for the cost of additional hospital days beyond the discharge date if the original decision to discharge is upheld.

SNF, CORF, and HHA Termination of Services Appeals

Discharges from care provided by a Skilled Nursing Facility (SNF) (including a swing bed in a hospital providing Part A and Part B services), Comprehensive Outpatient Rehabilitation Facility (CORF), or Home Health Agency (HHA) are subject to an expedited (fast-track) Member Appeal process. For this purpose, a discharge means the complete termination of services and not the termination of a single service when other services continue (e.g., when the Member is receiving skilled nursing, skilled therapy, and home health aide services from an HHA, and only the home health aide services are terminated while the other services continue).

When a single service is terminated and other services continue, an Integrated Denial Notice (IDN) with Member appeal rights is issued to the Member. Members receive their discharge appeal rights through the delivery of the Notice of Medicare Non-Coverage (NOMNC) by the SNF, CORF, or HHA. For additional information on delivery of the NOMNC, see the Termination of SNF, CORF, and HHA Services subsection located in the Health Care Services of this Provider Manual.

Members disputing their discharge decision may request an expedited (fast-track) Appeal to the QIO for the service area (Livanta or Kepro). The Member must appeal to the QIO by noon of the calendar day after the NOMNC is delivered. The QIO will typically respond by the effective date provided in the NOMNC (the last covered day).

If the QIO agrees with the discharge decision, the Member will be responsible for payment for continued care received beyond the last covered day provided in the NOMNC. The Member has an opportunity to request a reconsideration from the QIO if he/she remains in the SNF or continues to receive services from the CORF or HHA beyond the last covered day provided in the NOMNC. If the QIO continues to agree with the discharge decision, the Member may appeal to an Administrative Law Judge (ALJ) or attorney adjudicator.

If the QIO disagrees with the discharge decision, the Member is not responsible for any continued care (aside from any applicable deductibles or co-payments) without proper notification that includes their appeal rights located within the NOMNC. The Member will then have an opportunity to appeal that subsequent termination of services (discharge) determination.

If the Member misses the deadline to file an Appeal with the QIO and is still in the SNF or continuing to receive services from the CORF or HHA beyond the last covered day provided in the NOMNC, the Member (or their authorized representative) may request an expedited pre-service Appeal with the Plan. In this case, the Member does not have financial protection

during the course of the expedited pre-service Appeal and may be financially liable for paying for the cost of additional services provided beyond the discharge date (last covered day) if the original decision to discharge is upheld.

Obtaining Additional Information About the Member Appeal Process

For additional information about Member appeal rights, call Molina's Member Services team at **(877) 901-8181** or 711, for persons with hearing impairments (TTY/TDD). A detailed explanation of the appeal process is also included in the Member's Evidence of Coverage (EOC) or Member Handbook, which is available on Molina's website.

Medicare Member Grievances

A Member may file a grievance verbally or in writing within 60 days of the event precipitating the grievance. (Members enrolled in a Medicare-Medicaid Plan (MMP) may file a Grievance at any time, except a Part D Grievance. Part D Grievances must be filed within 60 days of the event precipitating the Grievance.)

Grievances are typically responded to by the Plan within 30 days (with some variability for certain types of Grievances for Plans providing integrated Medicare and Medicaid benefits, such as a FIDE SNP or MMP). The Plan may also be allowed to take an extension under certain circumstances.

Medicare allows an expedited grievance only if the Plan diverts an expedited request for an Organization Determination, Coverage Determination, or appeal, or if the Plan takes an extension in making an Organization Determination or Coverage Determination or deciding an appeal (when allowed). These expedited grievances are decided within 24 hours.

Members may file a Grievance by calling Member Services at **(877) 901-8181** or by writing to:

Molina Healthcare of Illinois, Inc.
Attn: Grievances and Appeals
P.O. Box 22816
Long Beach, CA 90801-9977

Fax: (562) 499-0610

17. Medicare Part D

A Part D coverage determination is a decision about whether to provide or pay for a Part D drug, a decision concerning a tiering exception request, a formulary exception request, a decision on the amount of cost-sharing for a drug, or whether a Member has or has not satisfied a Prior Authorization or other UM requirement.

Any party to a coverage determination (e.g., a Member, a Member's representative, or a Member's prescriber) may request that the determination be appealed. A Member, a Member's representative, or Provider are the only parties who may request that Molina expedite a coverage determination or redetermination.

Coverage determinations are either standard or expedited, depending on the urgency of the Member's request.

Appeals/Redeterminations

When a Member's request for a coverage determination is denied, Members may choose someone (including an attorney, Provider, or other authorized representative) to serve as his/her personal representative to act on his/her behalf. After the date of the denial, a Member has up to 60 days to request a redetermination. This is the first level of appeal for Part D adverse decisions. Appeal data is confidential.

The redetermination request will be responded to within seven days. If an expedited appeal is required for an emergent situation, then the decision will be made within 72 hours of the request.

At any time during the appeal process, the Member or personal representative may submit written comments, papers, or other data about the appeal in person or in writing. If the appeal/reconsideration is denied, the Member has the right to send the appeal to the Independent Review Entity (IRE) within 60 days of receipt of the appeal. The IRE has seven days to make a decision for a standard appeal/reconsideration and 72 hours for an expedited request. The IRE will notify Molina and the Member of the decision. When an expedited review is requested, the IRE will make a decision within 72 hours.

If the IRE changes the Molina decision, authorization for service must be made within 72 hours for standard appeals and within 24 hours for expedited appeals.

Payment appeals must be paid within 30 days from the date the plan receives notice of the reversal.

If the IRE upholds Molina's denial, it will inform the Member of their right to a hearing with the Administrative Law Judge (ALJ) and will describe the procedures that must be followed to obtain an ALJ hearing.

CMS's IRE monitors Molina's compliance with determinations to decisions that fully or partially reverse an original Molina denial. The IRE is currently MAXIMUS Federal Services Inc.

Part D Prescription Drug Exception Policy

CMS defines a coverage determination as the first decision made by a plan regarding the prescription drug benefits a Member is entitled to receive under the plan, including a decision not to provide or pay for a Part D drug, a decision concerning an exception request, and a decision on the amount of cost-sharing for a drug.

An exception request is a type of coverage determination request. Through the exceptions process, a Member can request an off-formulary drug, an exception to the plan's tiered cost-sharing structure, and an exception to the application of a cost UM tool (e.g., step therapy requirement, dose restriction, or Prior Authorization requirement).

Molina is committed to providing access to Medically Necessary prescription drugs to Members of Molina. If a drug is prescribed that is not on Molina's formulary, the Member or Member's representative may file for an exception. All exceptions and appeals are handled at the plan level (on-site) and are not delegated to another entity. Please see below for contact information by plan for personnel who handle the exceptions. Members or the Member's representatives (which can include Providers and pharmacists) may call, write, fax, or email Molina's exception contact person to request an exception. Procedures and forms to apply for an exception may be obtained from the contact persons.

Part D exceptions and appeals contact information: call Molina at **(800) 665-3086** or fax **(866) 290-1309**.

The Policy and Procedure for Exceptions and Appeals will be reviewed by a Pharmacy and Therapeutics (P&T) Committee on an annual basis at minimum. Exception/Prior Authorization criteria are also reviewed and approved by a P&T Committee.

1. **Formulary**—A list of medications selected by Molina in consultation with a team of health care Providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Molina will generally cover the drugs listed in our formulary as long as the drug is Medically Necessary, the prescription is filled at a Molina network pharmacy, the prescription is being used for a medically accepted indication (i.e., either FDA-approved or compendia-supported for the diagnosis for which it is being used), and other plan rules are followed.

   Formularies may be different depending on the Molina plan and will change over time. Current formularies for all products may be downloaded from our website at MolinaHealthcare.com.

2. **Copayments for Part D**—The amount a patient pays depends on which drug tier the drug is in under the plan and whether the patient fills the prescription at a preferred network pharmacy.
   - Most Part D services have a copayment.

- Copayments cannot be waived by Molina per CMS.
- Copayments for Molina may differ by state and plan.

3. **Restrictions on Molina's Medicare Drug Coverage**—Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:
   - **Prior Authorization:** Molina requires Prior Authorization for certain drugs, some of which are on the formulary and some of which are not on the formulary. Without prior approval, Molina may not cover the drug.
   - **Quantity Limits:** For certain drugs, Molina limits the amount of the drug that it will cover.
   - **Step Therapy:** In some cases, Molina requires patients to first try certain drugs to treat a medical condition before it will cover another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, Molina may not cover Drug B unless Drug A is tried first.
   - **Part B Medications:** Certain medications and/or dosage forms listed in this formulary may be available on Medicare Part B coverage depending upon the place of service and method of administration. Newly FDA-approved drugs 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 P&T Committee.

4. **Non-Covered Molina Medicare Part D Drugs**—The following are **not** covered under Part D:
   - Agents when used for anorexia, weight loss, or weight gain (no mention of Medically Necessary).
   - Agents when used to promote fertility.
   - Agents used for cosmetic purposes or hair growth.
   - Agents used for symptomatic relief of cough or colds.
   - Prescription vitamins and minerals, except those used for prenatal care and fluoride preparations.
   - Non-prescription drugs, except those medications listed as part of Molina's Medicare over-the-counter (OTC) monthly benefit, as applicable and depending on the plan.
   - Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale.
   - Molina Members with Medicaid coverage may have a limited selection of these excluded medications as part of its Medicaid coverage for Members assigned to Molina Medicaid.
   - Prescriptions that are not being used for a medically accepted indication; i.e., prescriptions must either be FDA-approved or compendia-supported for the diagnosis for which they are being used; the Medicare-approved compendia are

American Hospital Formulary Service Drug Information (AHFS) and DRUGDEX® Information System.

5. **Possible differences between the Medicare and Medicaid Formularies**—The Molina Formulary includes many injectable drugs not typically found in its Medicaid formularies, such as those for the aged, blind, and disabled.

6. **Requesting a Molina Medicare Formulary Exception**—Molina Medicare product drug Prior Authorizations are called Exceptions, which are required when your patient needs a drug that is not on the Formulary. A Member, a Member's appointed representative, or a Member's prescribing Provider are permitted to file an Exception. (The process for filing an Exception is predominantly a fax-based system.) The form for Exception requests is available on the Molina website.

7. **Requesting a Molina Medicare Formulary Redetermination (Appeal)**—The appeal process involves an adverse determination regarding Molina issuing a denial for a requested drug or claim payment. If the Member received a Notice of Denial of Medicare Prescription Drug Coverage and disagrees with the decision rendered, he/she may request a redetermination (appeal) from Molina by completing the appeal form sent with the Notice of Denial.

   A Member, a Member's appointed representative, or a Member's prescribing Provider (for expedited appeals) may complete the appeal form and submit any information that may help Molina with the processing of the appeal. An appeal must be submitted in writing and filed within 60 calendar days from the date that the determination was rendered.

   - A standard appeal may be submitted to Molina in writing. The appeal will be reviewed upon receipt, and the Member will be notified in writing within seven calendar days from the date the request for redetermination is received.
   - An expedited appeal can be requested by the Member or by a Provider acting on behalf of the Member in writing or can be taken over the phone. An expedited appeal may be requested in situations where applying the standard time frame could seriously jeopardize the Member's life, health, or ability to regain maximum function. If a Provider supports the request for an expedited appeal, Molina will honor this request.
   - If a Member submits an appeal without Provider support, Molina will review the request to determine if it meets Medicare's criteria for expedited processing. If the plan determines that the request meets the expedited criteria, Molina will render a decision as expeditiously as the Member's health requires, but not exceeding 72 hours. If the request does not meet the expedited criteria, Molina will render a coverage decision within the standard redetermination time frame of seven calendar days.
   - To submit a verbal request, please call **(800) 665-3086**. Written appeals must be faxed to **(866) 290-1309**.
   - A Claims Dispute Request Form is required when submitting via fax. The completed Claims Dispute Request Form, along with supporting documentation may be faxed

to Molina at **(855) 502-4962**. The Claims Dispute Request Form may be accessed on Molina's website at: molinahealthcare.com/Providers/il/PDF/Medicaid/Claims_Dispute_Request_Form.pdf

8. **Initiating a Part D Coverage Determination Request**—Molina will accept requests from Providers or a Member's appointed representative on the behalf of the Member either by a written or verbal request. The request may be communicated through the standardized Molina Medication Prior Authorization Request Form or via fax and telephone. All requests will be determined, and an approval or denial decision will be communicated to the Member and the Member's prescribing Provider within 72 hours/three calendar days after Molina receives the completed request.

   Molina will request submission of additional information if a request is deemed incomplete for a determination decision. All requests may be approved by 1) Molina Pharmacy Technician under the supervision of a pharmacist, 2) Molina Pharmacist, or 3) Chief Medical Officer (CMO) of Molina. Review criteria will be made available at the request of the Member or his/her prescribing Provider.

   Molina will determine whether a specific off-label use is a medically accepted indication based on the following criteria:

   a. A prescription drug is a Part D drug only if it is for a medically accepted indication, which is supported by one or more citations included or approved for inclusion within the following compendia:
      - American Hospital Formulary Service Drug Information.
      - DRUGDEX Information System.

   b. Requests for off-label use of medications must be accompanied with excerpts from one of the two CMS-required compendia for consideration. The submitted excerpts must cite a favorable recommendation.

   c. Depending upon the prescribed medication, Molina may request the prescribing Provider to document and justify off-label use in clinical records and provide information such as diagnostic reports, chart notes, and medical summaries.

   Denial decisions are only given to the Member or Member's representative by a Pharmacist or CMO of Molina. The written denial notice to the Member (and the prescriber involved) includes the specific rationale for denial, the explanation of both the standard and expedited appeals process, and an explanation of a Member's right to, and conditions for, obtaining an expedited appeals process.

   If Molina denies coverage of the prescribed medication, Molina will give the Member a written notice within 72 hours explaining the reason for the denial and how to initiate the appeals process. If no written notice is given to the Member within the specified time frame, Molina will start the next level of appeal by sending the Coverage Determination Request to the IRE within 24 hours.

   If a coverage determination is expedited, Molina will notify the Member of the coverage determination decision within the 24-hour time frame by telephone and will mail the

Member a written Expedited Coverage Determination within three calendar days of the oral notification. If Molina does not give the Member a written notification within the specified time frame, Molina will start the next level of appeal by sending the coverage determination request to IRE within 24 hours.

9. **Initiating a Part D Appeal**—If Molina's initial coverage determination is unfavorable, a Member may request a first level of appeal, or redetermination within 60 calendar days from the date of the notice of the coverage determination. In a Standard Appeal, Molina has up to seven days to make the redetermination, whether favorable or adverse, and notify the Member in writing within seven calendar days from the date the request for redetermination is received. Member or a Member's prescribing Provider may request Molina to expedite a redetermination if the standard appeal time frame of seven days may seriously jeopardize the Member's life, health, or ability to regain maximum function. Molina has up to 72 hours to make the redetermination, whether favorable or adverse, and notify the Member in writing within 72 hours after receiving the request for redetermination. If additional information is needed for Molina to make a redetermination, Molina will request the necessary information within 24 hours of the initial request for an expedited redetermination. Molina will inform the Member and prescribing Provider of the conditions for submitting the evidence, since the time frame is limited on expedited cases.

10. **The Part D Independent Review Entity (IRE)**—If the redetermination is unfavorable, a Member may request reconsideration by the IRE. The Part D Qualified Independent Contractor is currently MAXIMUS Federal, a CMS contractor that provides second-level appeals.
    - **Standard Appeal:** The IRE has up to seven days to make the decision.
    - **Expedited Appeal:** The IRE has up to 72 hours to make the decision.
    - **Administrative Law Judge (ALJ):** If the IRE's reconsideration is unfavorable, a Member may request a hearing with an ALJ if the amount in controversy requirement is satisfied. **Note**: Regulatory time frame is not applicable on this level of appeal.
    - **Medicare Appeals Council (MAC):** If the ALJ's finding is unfavorable, the Member may appeal to the MAC, an entity within the Department of Health and Human Services that reviews ALJ's decisions. **Note**: Regulatory time frame is not applicable on this level of appeal.
    - **Federal District Court (FDC):** If the MAC's decision is unfavorable, the Member may appeal to an FDC if the amount in controversy requirement is satisfied. **Note**: Regulatory time frame is not applicable on this level of appeal.

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 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 (SUD) 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.

18. Delegation

Delegation is a process that gives another entity the ability to perform specific functions on behalf of Molina. Molina may delegate:

- Utilization Management.
- Credentialing and recredentialing.
- 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; such reports are reviewed by Molina Delegation Oversight staff for compliance with performance expectations 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.