



**Molina Healthcare of California
Provider/Practitioner Manual**

Compliance

	Document Page #
Oversight	2 – 7
Anti-Fraud Program	8 – 11
HIPPA Requirements and Information	12 – 15

SECTION 25: OVERSIGHT MONITORING

COMPLIANCE AND OVERSIGHT MONITORING

The Medi-Cal Contract between the Department of Health Care Services (DHCS) and Molina Healthcare defines a number of performance requirements that must be satisfied by both Molina Healthcare and those Providers/Practitioners and IPA/Medical Groups/Hospitals agreeing, through descending contracting relationships (or subcontracts), to provide services to eligible and enrolled Molina Healthcare members. Among these are:

- ▶ The Provider/Practitioner’s agreement to participate in medical and other audits (e.g. Health Effectiveness Data Information Set (HEDIS) and/or mandated) conducted by DHCS, other regulatory agencies, or Molina Healthcare.
- ▶ The Provider/Practitioner’s agreement to maintain books and records for a period of seven (7) years and make such documents available to regulatory agencies.
- ▶ The Provider/Practitioner’s agreement to furnish Molina Healthcare with encounter data.

Providers/Practitioners are encouraged to review their contracts with Molina Healthcare to become thoroughly familiar with these and additional performance requirements.

Compliance Reporting Requirements for IPAs/Medical Groups/Hospitals

Molina Healthcare routinely monitors its network of delegated capitated IPAs/Medical Groups/Hospitals for compliance with various standards. These requirements include but are not limited to:

Claims Timeliness Reporting/Audits

- ▶ Molina Healthcare requires the delegated capitated IPAs/Medical Groups/Hospitals to submit monthly claims timeliness reports. These reports are due to Molina Healthcare by the 15th of each month for all claims processed in the previous month. 90% of “clean” claims are to be processed within thirty (30) calendar days of receipt. 100% of all claims are to be processed within forty five (45) working days. *Refer to Section 22 for Molina Healthcare’s claim processing requirements*
- ▶ Molina Healthcare requires the delegated capitated IPAs/Medical Groups/Hospitals to achieve passing claims audit scores. Claims audits are conducted annually. More frequent audits are conducted when the IPA/Medical Group/Hospital does not achieve the timely processing requirements referenced above.

Claims Settlement Practices and Dispute Resolution Mechanism

- ▶ Molina Healthcare requires IPAs/Medical Groups/Hospitals to submit quarterly claims timeliness reports. These reports are due to Molina Healthcare on or before the last calendar day of the month after the last month of each calendar quarter.
- ▶ The Designated Principal Officer for Claims Settlement Practices must sign the Quarterly Claims Reports.
- ▶ Molina Healthcare also requires IPAs/Medical Groups/Hospitals to submit quarterly Provider Dispute Resolution Reports. These reports are also due on or before the last calendar day of the month after the last month of each calendar quarter.
- ▶ The Designated Principal Officer for the Dispute Resolution Mechanism must sign the Quarterly Provider Dispute Resolution Reports.
- ▶ These quarterly reports are due as follows:

<u>Calendar Quarter</u>	<u>Due Date</u>
First Quarter	April 30th
Second Quarter	July 31st
Third Quarter	October 31st
Fourth Quarter	January 31st

- Molina Healthcare will conduct an annual PDR audit. More frequent audits will be conducted when the IPA/Medical Group/Hospital does not meet the PDR requirements.

Encounter Data Reporting

- Molina Healthcare will accept encounter data via hard copy (CMS 1500 form, UB04 form) or electronically (in specified formats). Electronic encounter data is due to Molina Healthcare within ninety (90) days from the end of the month following the encounter. (e.g., by October 31st for all encounters occurring in July.) Hard copy encounter data is due to Molina Healthcare by the 5th day of the second month following the encounter (i.e., by August 5th for encounters occurring in June). *Please refer to Section 23 for Molina Healthcare's encounter data requirements.*

Financial Reporting/Viability

- Quarterly financial statements are due to Molina Healthcare within forty five (45) calendar days from the end of the IPAs/Medical Group's/Hospital's fiscal quarter. The quarterly financial statements need not be certified by outside auditors, but must be accompanied by a financial statement certification form signed by the Chief Financial Officer or President of the IPA/Medical Group/Hospital. Audited annual statements are due within one hundred twenty (120) calendar days, but no later than one hundred fifty (150) days, from the end of each IPAs/Medical Group's/Hospital's fiscal year. The audited annual statement must include footnote disclosures, and be prepared by an independent Certified Public Accountant in accordance with generally accepted accounting principles (GAAP). All statements must be submitted on time, and meet Molina Healthcare's viability standards: 1) current assets are greater than current liabilities and 2) tangible net equity is positive. Quarterly viability cannot be determined if the organization has not submitted their most recent annual audited statement.

In accordance with SB 260 (Financial Solvency Reporting), the IPA/Physician Group must also submit a quarterly financial survey report to the Department of Managed Health Care (DMHC) within forty five (45) calendar days from the end of the IPA/Physician Group's fiscal quarter.

The IPA/Physician Group must also submit an annual financial survey report to DMHC within one hundred fifty (150) calendar days from the end of the IPA/Physician Group's fiscal year.

The IPA/Physician Group must also submit a copy of their DMHC certification and/or survey to MHC which will show that the quarterly and/or annual survey has been completed.

In addition, MHC must also review each IPA/Physician Group's cash-to-claims ratio, which is determined based on receivables collectable within sixty (60) days. In order to know what is collectable within sixty (60) days, MHC needs a copy of the screen print of the Balance Sheet and the Grading Criteria page, which was completed as part of the IPA/Physician Group's survey on DMHC's web site.

Utilization Management Reporting

- Molina Healthcare requires capitated/delegated IPA/Medical Groups to submit utilization management reports in accordance with their Utilization Management Delegation Agreement.
- Molina Healthcare's Delegation Oversight Department is responsible for systematic monitoring and annual audits of each delegated IPA/Medical Group and health plan partner to ensure their ability to perform delegated functions and adherence to all applicable regulatory and accreditation standards.
- In order to achieve and maintain delegation status for UM activities the delegate must demonstrate ongoing, functioning systems are in place and meet the required UM operational standards and reporting requirements.

Molina Healthcare conducts its own Quality Improvement (QI) program. The IPA/Medical Groups and Providers/ Practitioners agree to abide by and participate in Molina Healthcare's QI program.

Quality Oversight Monitoring

Under the terms of its contract with DHCS, Molina Healthcare conducts ongoing reviews of Provider/Practitioner performance. Among the elements to be reviewed are the following:

- ▶ Conducts an annual or more frequent geo-access audit to determine geographic, PCP and Specialist gaps in the network. The data provides information for contracting strategies.
- ▶ Molina also conducts at least annual cultural, ethnic, racial and linguistic geo-access survey to assess availability of practitioners to meet the member's needs and determine network gaps. The data provides information for contracting strategies.
- ▶ Molina conducts an annual telephonic survey to review the time it takes members to access emergency care, urgent care, nonurgent (routine) care, specialty care, initial health assessments, first prenatal visits, physical exams, and wellness checks in accordance with access standards disclosed in Section 5, Access to Care.

Member Complaint and Grievance Indicators - Member concerns specific to the care and services of specific Providers/Practitioners are collected and acted upon by Molina Healthcare's Member Services Department. Providers/Practitioners are engaged in the review of specific concerns and will be asked to assist in remedial endeavors, as indicated.

The outcomes and findings of the foregoing and other performance indicators are reviewed by Molina Healthcare's Quality Improvement Department and by Molina Healthcare's Quality Improvement Committee.

Quality Improvement Corrective Action Plans

When it is found that Providers/Practitioners or IPAs/Medical Groups do not meet the terms of their contracts, applicable policies and procedures, licensing and related requirements, and the provisions of this Manual, they will be notified in writing of deficiencies. Quality Improvement Corrective Action Plans (CAP) will be forwarded to Providers/Practitioners and will include corrective actions and dates by which corrective actions are to be achieved.

Molina Healthcare representatives will work with and offer support to Providers/Practitioners to ensure the timely resolution of CAP requirements.

Providers/Practitioners who fail to respond to an initial corrective action plan by the date specified will be provided a second iteration of CAP requirements and may be assigned an extended action plan due date.

Non-Compliance With Quality Improvement Corrective Actions

Molina Healthcare's Quality Improvement Department coordinates and assists the Provider/Practitioner with the development and implementation of the corrective action plan. Non-compliance with Quality Improvement corrective actions may result in any of the following:

- ▶ Contact by the Molina Healthcare's Quality Improvement Department
- ▶ Conduct in-service/education
- ▶ Referral to the IPA or Medical Group for corrective action
- ▶ Implementation of Provider/Practitioner Compliance Department corrective action program which may result in the following sanctions:
 - ▶ The termination of new member enrollments
 - ▶ Moving current members to another IPA/Medical Group where the Provider/Practitioner is affiliated
 - ▶ Formal contract termination

Re-Audits

Re-audits are conducted to assure corrective actions have been effective in improving compliance with previously identified deficiencies.

QUALITY IMPROVEMENT PROGRAM

Purpose

The purpose of the Molina Healthcare of California (Molina) Quality Improvement Program is to establish methods for objectively and systematically evaluating and improving the quality of care and service provided to Molina Medicaid (MediCal and persons with disabilities), SCHIPS (Healthy Families), Medicare (Molina Medicare Options (Medicare A and B) and Molina Medicare Options Plus (full dual eligible) members. Molina strives to continuously improve the structure, processes and outcomes of its health care delivery system.

The Molina Quality Improvement Program promotes a commitment to quality in every facet of the health plan's structure and processes. It relies on senior management oversight and accountability, and integrates the activities of all health plan departments in meeting the program's goals and/or objectives. The Quality Improvement Program involves all key stakeholders, members, participating practitioners, providers and health plan staff, in the development, evaluation and planning of quality improvement activities.

The Molina Quality Improvement Program incorporates a continuous, quality improvement methodology that focuses on the specific needs of its internal and external customers. It is organized to identify and analyze significant opportunities for improvement in delivery of health care and service, to develop improvement strategies, and to track systematically, if these strategies result in progress toward benchmarks or goals. The methodology includes pursuing our goals in a culturally competent manner.

The written Quality Improvement Program defines the goals, objectives, scope, structure, committees and functions of the program. The Quality Improvement Program is reviewed and updated annually and presented to the Quality Improvement Committee (QI Committee) and to the Board of Directors for approval.

Scope of the QIP Program

The Molina Healthcare Quality Improvement Program encompasses the quality of acute, chronic, and preventive clinical care and service provided in both the inpatient and outpatient setting by hospitals and facilities, participating provider groups, primary care and specialty practitioners, and ancillary providers.

Its specific concerns include:

1. The continuity and coordination of care.
2. The over-and-under-utilization of services.
3. The access to and availability of routine, urgent and, emergency care.
4. The health status of Molina members of all products.
5. Provider and practitioner qualifications and performance.
6. The environmental, physical, and clinical safety of Molina Healthcare members.
7. The implementation of preventive health and clinical practice guidelines.
8. Member and practitioner satisfaction.
9. The effectiveness of health plan services including member education and services, practitioner relations and services, credentialing, utilization and case management, claims adjudication, risk management, and pharmacy management.
10. The ethnic and linguistic appropriateness of care and service.
11. Behavioral health services applicable for the Healthy Families product only. The services are managed by an NCQA accredited MBHO. These services are excluded from Molina Healthcare's Medi-Cal contract
12. Assessing the effectiveness of quality improvement activities

PROVIDER/PRACTITIONER REVIEW PROCESS

Provider/Practitioner Facility Site Review

- ▶ Molina Healthcare's responsibility to its members is to contract with providers of health care who provide safe, comfortable offices, and deliver high quality medical care.
- ▶ The Provider/Practitioner is reviewed every three (3) years using the current DHCS approved facility site review survey tool. All cyclic and appropriate follow-up and focused reviews are scheduled in advance, by telephone, with written confirmation of the dates being faxed to the facility.
- ▶ Results of each review are reviewed by the Facility Site Review Unit of the Credentialing Department for compliance with and maintenance of standards. Results of the completed site review are discussed with the Provider/Practitioner at the time of the review and a written copy is left with the Provider/Practitioner. The IPA/Medical Group is involved as needed by the Facility Site Review Unit. When required, Corrective Action Plans are developed, based on the scoring criteria and noted deficiencies and left with the Provider/Practitioner at the time of the review. For more details on Facility Site Review and review forms, please refer to Section 21, titled Physician Facility Reviews.

Medical Record Review

- ▶ Molina Healthcare has a responsibility to ensure that Providers/Practitioners maintain appropriate medical records showing that appropriate care has been provided to members. This includes pediatric and adult preventive care.
- ▶ The Provider/Practitioner is reviewed every three (3) years using the current DHCS approved medical record review survey tool. All cyclic and appropriate follow-up and focused reviews are scheduled in advance, by telephone, with written confirmation of the dates being faxed to the office.
- ▶ Results of each review are reviewed by the Facility Site Review Unit of the Credentialing Department for compliance with and maintenance of standards. Results of the completed Medical Record review are discussed with the Provider/Practitioner at the time of the review and a written copy is left with the Provider/Practitioner. The IPA/Medical Group is involved as needed by the Facility Site Review Unit. When required, Corrective Action Plans are developed, based on the scoring criteria and deficiencies and left with the Provider/Practitioner at the time of the review. For more details, refer to Section 19, titled Medical Record Documentation.

Child Health and Disability Prevention (CHDP) Reviews

- ▶ The CHDP, a part of the Children's Medical Services State Program, is a preventive health program serving California's children and youth under the age of 21. Through the CHDP program, regular preventive health assessments to identify and treat problems, or suspected problems, are available to eligible children and youth to prevent or reduce the severity of illnesses. Through this program, Molina Healthcare provides preventive health care to eligible members together with the continuity that comes with care provided by the member's selected Primary Care Practitioner (PCP).
- ▶ Incorporated into the Medical Record Review Tool are CHDP specific questions. The Provider/Practitioner to be reviewed will be advised in advance, either by telephone or in writing, of the date for the review. A specific number of records will be reviewed by a licensed Molina Healthcare staff member. The CHDP review may be done concurrently with the medical record review.
- ▶ Any Provider/Practitioner not meeting CHDP standards will be so advised in writing. Corrective actions will be implemented as necessary following the audit. Details pertaining to the CHDP Program are in Section 11, titled Pediatric and Child Health Services.

Comprehensive Perinatal Services Program (CPSP) Review

The CPSP is designed to increase access to prenatal care and to improve pregnancy outcomes. The services of this program include health and nutrition education, psychosocial assessment, treatment planning, and periodic reassessment. CPSP must be offered to all Molina Healthcare Medi-Cal members, but participation is voluntary. Refusal of CPSP must be documented in the patient's obstetrical record.

DELEGATED IPAs AND MEDICAL GROUPS:

Molina Healthcare does not delegate any Quality Improvement Activities to any contracted Provider/Practitioner or IPA/Medical Group organization.

OVERSIGHT MONITORING OF UTILIZATION AND CREDENTIALING PROGRAMS FOR DELEGATED PROVIDERS

Molina Healthcare may delegate responsibility for activities associated with utilization management (UM) and credentialing, to its IPAs/Medical Groups. Prior to approval of delegation, and at least annually thereafter, Molina Healthcare conducts an onsite review of IPAs/Medical Groups requesting delegation. Molina Healthcare uses delegation standards in compliance with NCQA, State and Federal Requirements. A member or designee of the delegation oversight team assigned to evaluate and oversee the IPAs/Medical Groups activities conducts the evaluation. Based on the audit scores and findings, if required thresholds and criteria are met, the appropriate peer review Committee may grant specific delegation functions to the IPA/Medical Group to perform. If approved for delegation, a delegation agreement must be executed between Molina Healthcare and the IPA/Medical Group. A "Delineation of Responsibilities" grid is included with the Delegation Agreement, outlining the delegated activities; Molina Healthcare's Responsibilities; the Delegated IPA/Medical Group Responsibilities; the Frequency of Reporting; Molina Healthcare's Process for Evaluating Performance; and, Corrective Actions if the IPA/Medical Group fails to meet responsibilities.

Molina reserves the right to request corrective action plans or revoke the delegation of these responsibilities when the Delegated group demonstrates noncompliance to NCQA State and Federal Requirements.

Complex Case Management services are not delegated to IPAs/Medical Groups. Molina Healthcare's Medical Case Management Department retains sole responsibility for authorization and implementation of these services. IPAs/Medical Groups are required to refer known or potential cases to Molina Healthcare Case Management. The referral may be made by a telephone or facsimile. This information can also be found in the Utilization Management, Section 8, and in the Public Health Coordination and Case Management, Section 9.

ANTI-FRAUD PROGRAM

About Healthcare Fraud

Healthcare fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized health care benefits. Molina Healthcare of California (“MHC”) in accordance with (42 CFR § 455.2 and as further defined in welf. & Inst. Code Section 14034.1 (a).) regards health care fraud as unacceptable, unlawful, and harmful to the provision of quality health care in an efficient and affordable manner. Any person convicted of health care fraud faces imprisonment and substantial fines.

How Healthcare Fraud Affects Everyone

Why should you care about healthcare fraud, because health care fraud directly affects each of us and impacts the cost of healthcare benefits for everybody. It is estimated that losses due to fraud adds three (3%) to ten (10%) percent to the annual cost of healthcare in the United States. Health care fraud can also impact the quality of care that a Member receives. Health care fraud includes but is not limited to the making of intentional false statements, misrepresentations or deliberate omissions of material facts from, any record, bill, claim or any other form for the purpose of obtaining payment, compensation or reimbursement for health care services.

Examples of Fraud and Abuse

By a Member	By a Provider
Using someone else’s insurance card.	False coding, records, or altered claims.
Forging a prescription.	Billing for services not rendered or goods not provided.
Knowingly enrolling someone not eligible for coverage under their policy or group coverage.	Billing separately for services that should be a single service.
Providing misleading information on or omitting information from an application for health care coverage, or intentionally giving incorrect information to receive benefits.	Billing for services not medically necessary.
Altering the billed amount for services. Altering the service date.	Overutilization: Medically unnecessary diagnostics, unnecessary durable medical equipment, unauthorized services, inappropriate procedure for diagnosis.

What Molina Healthcare is Doing About Healthcare Fraud

Molina Healthcare takes a proactive approach to detecting and investigating potential healthcare fraud and abuse. Molina Healthcare has a comprehensive Anti-Fraud Program designed to combat health care fraud activities. Molina Healthcare works with state and federal agencies to prevent, uncover; report and stop fraud. Molina Healthcare’s aggressive approach to the investigation of potential healthcare fraud cases is reflected in the Molina Healthcare’s Mission Statement.

The mission of Molina Healthcare is to implement an anti-fraud program to prevent, investigate and report suspected healthcare fraud in order to reduce healthcare costs and to promote quality healthcare. Molina Healthcare strives to protect all healthcare dollars that otherwise might be lost or wasted. Molina Healthcare works with Members and Providers/Practitioners to address issues and concerns about fraud and abuse.

Deficit Reduction Act (DRA)

On February 8, 2006, President Bush signed into law the Deficit Reduction Act (“DRA”). The Deficit Reduction Act (DRA) was enacted to bring monetary spending under control. The DRA aims to cut \$11 billion from the Medicare and Medicaid programs by 2012 by deterring and preventing fraud, waste, and abuse.

As a Provider/Practitioner to Molina Healthcare members, you are either a cover entity or contractor/agent, as a contractor/agent you are required to follow Molina Healthcare’s policy and procedures on the DRA, fraud and abuse. Health care entities like Molina Healthcare who receive or pay out at least \$5 million in Medicaid funds per year must comply with DRA. These 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/Practitioners will detect and prevent fraud, waste, and abuse;
- Employee protected rights as whistleblowers.

Federal False Claims Act, 31 USC Section 3279

The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. 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; or
- 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.

The Federal False Claims Act and the Medicaid False Claims Act also have Qui Tam language commonly referred to as “whistleblower” provisions. 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 acts. The whistleblower may also file a lawsuit on their own. 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 furthering 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, contractors or agents who fail to comply with the law will be at risk of forfeiting all Medicaid payments until compliance is met. Molina Healthcare will take steps to monitor Molina Healthcare contracted Providers/Practitioners to ensure compliance with the law.

For more information on this legislation, or obtain a copy of Molina Healthcare's policy and procedures on the DRA, Fraud and Abuse, please contact your Molina Healthcare Provider Services Representative.

How to report potential fraud

You may report suspected cases of fraud and abuse to Molina's Compliance Officer. You have the right to have your concerns reported anonymously to Molina, the California Department of Health Services, and/or United States Office of Inspector General. When reporting an issue, please provide as much information as possible. The more information provided the better the chance the situation will be successfully reviewed and resolved. Remember to include the following information when reporting suspected fraud or abuse:

- Nature of complaint
- The names of individuals and/or entity involved in suspected fraud and/or abuse including address, phone number, Medicaid ID number and any other identifying information.

Potential fraud and abuse may be reported through one of the following:

- **TELEPHONE**

Call the Toll-Free number of the Molina Healthcare of California , Compliance Anti-Fraud Line:
(866) 449-6850

- **FAX**

Fax the Toll-Free number of the Molina Healthcare of California , Compliance Anti-Fraud Line:
(562) 499-6150

- **E-MAIL**

MHC_Compliance@Molinahealthcare.com

- **REGULAR MAIL**

Write (marked confidential) to:
Compliance Officer
Molina Healthcare of California
200 Oceangate, Suite 100
Long Beach, CA 90802

You may also report fraud and abuse to the California Department of Health Services, or United States Office of Inspector General by calling:

- Call the toll-free number of the Department of Health Services Anti-Fraud Line:
(800) 822-6222

- Call the toll-free number of the Office of Inspector General:
(800) 447-8477

HIPAA REQUIREMENTS AND INFORMATION

HIPAA (The Health Insurance Portability and Accountability Act)

Molina Healthcare's Commitment to Patient Privacy

Protecting the privacy of members' personal health information is a core responsibility that Molina Healthcare takes very seriously. Molina Healthcare is committed to complying with all federal and state laws regarding the privacy and security of members' protected health information (PHI).

Provider/Practitioner Responsibilities

Molina Healthcare expects that its contracted Providers/Practitioners will respect the privacy of Molina Healthcare members and comply with all applicable laws and regulations regarding the privacy of patient and member PHI.

Applicable Laws

Providers/Practitioners must understand all state and federal healthcare 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/Practitioners must comply with. In general, most healthcare Providers/Practitioners are subject to various laws and regulations pertaining to privacy of health information including, without limitation, the following:

1. Federal Laws and Regulations
 - HIPAA
 - Medicare and Medicaid laws
2. Applicable State California Laws and Regulations

Providers/Practitioners 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/Practitioners should consult with their own legal counsel to address their specific situation.

Uses and Disclosures of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a Provider/Practitioner may use and disclose PHI for their own treatment, payment, and healthcare operations activities (TPO) 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/Practitioner's own TPO activities, but also for the TPO of another covered entity¹ Disclosure of PHI by one covered entity to another covered entity, or healthcare provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

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

1. A covered entity may disclose PHI to another covered entity or a healthcare 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;
 - Case management and care coordination;
 - Training Programs;
 - Accreditation, licensing, and credentialing

Importantly, this allows Providers/Practitioners to share PHI with Molina Healthcare for our healthcare operations activities, such as HEDIS and quality improvement.

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. A sample Authorization for the Use and Disclosure of Protected Health Information is included at the end of this section.

Patient Rights

Patients are afforded various rights under HIPAA. Molina Healthcare Providers/Practitioners must allow patients to exercise any of the below-listed rights that apply to the Provider/Practitioner’s practice:

1. *Notice of Privacy Practices*

Providers/Practitioners 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/Practitioner 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 healthcare Provider/Practitioner restrict its uses and disclosures of PHI. The Provider/Practitioner is not required to agree to any such request for restrictions.

3. *Requests for Confidential Communications*

Patients may request that a healthcare Provider/Practitioner communicate PHI by alternative means or at alternative locations. Providers/Practitioners must accommodate reasonable requests by the patient.

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

4. *Requests for Patient Access to PHI*

Patients have a right to access their own PHI within a Provider/Practitioner'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/Practitioner 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/Practitioner 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/Practitioner during the preceding six (6) year period. The list of disclosures does not need to include disclosures made for treatment, payment, or healthcare operations or made prior to April 14, 2003.

HIPAA Security

Providers/Practitioners should implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of member PHI. Providers/Practitioners should recognize that identity theft is a rapidly growing problem and that their patients trust them to keep their most sensitive information private and confidential.

In addition, medical identity theft is an emerging threat in the healthcare 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 healthcare 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 Healthcare.

HIPAA Transactions and Code Sets

Molina Healthcare strongly supports the use of electronic transactions to streamline healthcare administrative activities. Molina Healthcare Providers/Practitioners are encouraged to submit claims and other transactions to Molina Healthcare using electronic formats. Certain electronic transactions are subject to HIPAA's Transactions and Code Sets Rule including, but not limited to, the following:

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

Molina Healthcare is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers/Practitioners who wish to conduct HIPAA standard transactions with Molina Healthcare should refer to Molina Healthcare's website at <http://www.molinahealthcare.com> for additional information. Click on the tab titled "Providers", select a state, click the tab titled "HIPAA" and then click on the tab titled "TCS readiness".

National Provider Identifier

Provider/Practitioners must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider/Practitioners must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider/Practitioner. The Provider/Practitioner must report its NPI and any subparts to Molina Healthcare 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 Healthcare within 30 days of the change. Provider/Practitioners must use its NPI to identify it on all electronic transactions required under HIPAA and on all claims and encounters (both electronic and paper formats) submitted to Molina Healthcare.

Additional Requirements for Delegated Providers/Practitioners

Providers/Practitioners that are delegated for claims and utilization management activities are the “business associates” of Molina Healthcare. Under HIPAA, Molina Healthcare must obtain contractual assurances from all business associates that they will safeguard member PHI. Delegated Providers/Practitioners must agree to various contractual provisions required under HIPAA’s Privacy and Security Rules.