Chapter 9
Provider Roles and Responsibilities

A. Provider Responsibilities

PCP Duties and Responsibilities

The PCP must provide a medical home to Members. The PCP must provide primary care to patients, maintain the continuity of patient care, and initiate and manage referrals for specialized care. Included within that responsibility are the following obligations:

- verifying eligibility,
- supervising, coordinating and providing initial and basic care to Members;
- initiating and authorizing their referral for specialist care, inpatient care, and other Medically Necessary services;
- following Members admitted to Inpatient Facilities;
- maintaining continuity of Member care.

Primary care services are all medical services required by a Member for the prevention, detection, treatment and cure of illness, trauma, or disease, which are covered and/or required services under the Texas Medicaid program.

The PCP must ensure that Members under the age of 21 receive all services required by HHSC including but not limited to the American Academy of Pediatrics (AAP) recommended schedule for CHIP Members and the THSteps periodicity schedule published in the THSteps Manual (located at Appendix VI) for Medicaid Members. Adults must be provided with preventive services in accordance with the U.S. Preventative Task Force requirements. All services must be provided in compliance with all generally accepted medical standards for the community in which services are rendered.

Note: *Network Providers who are Primary Care Physicians must have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. A Primary Care Physician may provide behavioral health related services within the scope of his/her practice.*

Specialty Care Provider Responsibilities

Some specialty services require a referral from the PCP. The Specialist may order diagnostic tests without PCP involvement; however, the Specialist may not refer to another specialist except in a true emergency situation. Specialists must abide by the referral and authorization guidelines as described in "What Requires Authorization."

The Specialist provider must:

- verify eligibility,

- obtain referral or authorization from the PCP before providing certain services,
- refer the member to another specialist provider,
- provide the PCP with consultation reports and other appropriate records in a timely manner,
- participate in Peer Review Process and be available for or provide on call coverage through another source 24 hours a day.

Long Term Services & Support Provider Responsibilities

Long term services and support providers are responsible to:

- Provide primary care services and continuity of care to assigned members via the medical home concept
- Verify member eligibility prior to performing services
- Adhere to the Molina Healthcare of Texas authorization policies
- Determine if members have medical benefits through other insurance coverage
- Ensure that there is ongoing continuity of care between the member's Molina Healthcare of Texas coordinator and the PCP
- Coordinate the care of members with Medicaid and Medicare programs, public health agencies and community resources that make medical, nutritional, behavioral, educational and outreach services available to members. This includes coordination with the WIC Special Supplemental Nutrition Program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin.
- Notify the plan whenever there is change in the member's physical or mental condition and a change in their eligibility

Member's Right to Designate an OB/GYN

Molina Healthcare of Texas Inc. does not limit your selection of an OB/GYN to your PCP's network.

ATTENTION FEMALE MEMBERS:

You have the right to select an OB/GYN without a referral from your PCP. The access to health care services of an OB/GYN includes:

- one well-woman check-up per year
- care related to pregnancy
- care for any female medical condition, and
- referral to specialist doctor within the network

Members Right to Designate an OB/GYN

Females may request an OB/GYN be their PCP especially during their pregnancy. If the OB/GYN agrees to be the PCP the physician must refer the Member if care outside of their scope of expertise is required. A certified nurse midwife may act as a PCP only during and immediately after a women's pregnancy.

Otherwise, specialists may serve as PCPs only as set forth. All PCPs must have admitting privileges to a hospital within the Molina network.

B. Provider Termination and Dismissal

Providers may terminate their agreement with Molina Healthcare upon sixty (60) days prior written notice in the event that provider rejects any written material modification to policies, procedures or products provided the notice is received no later than 30 days from the date the provider received the notification.

C. Request to Discharge a Member

It may become necessary for a PCP to discharge a member from his/her panel. Prior to discharging a member, the primary care physician must counsel the patient regarding the patient/physician relationship. Such counseling must be documented appropriately in the medical chart, an incident report or treatment plan. If the behavior does not improve, the PCP may request in writing to the Plan, the member be dismissed from his/her panel. The Member Services department will send written notification to the member advising them to select a new PCP. The PCP is required to continue treating the member for 30 days following the notification to the member.

D. Access and Availability

Emergency and After Hours Access

A Contracted Primary Care Provider must ensure that he/she will be available or accessible, or arrange to have another qualified medical professional available or accessible twenty-four (24) hours a day, seven (7) days a week.

The following are acceptable and unacceptable telephone arrangements for contacted PCPs after their normal business hours:

<u>Acceptable after-hours coverage</u>

- The office telephone is answered after-hours by an answering service, which meets language requirements of the Major Population Groups and which can contact the PCP or another designated medical practitioner.
- All calls answered by an answering service must be returned within 30 minutes;
- The office telephone is answered after normal business hours by a recording in the language of each of the Major Population Groups served, directing the patient to call another number to reach the PCP or another provider designated by the PCP.

- Someone must be available to answer the designated provider's telephone. Another recording is not acceptable; and
- The office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or another designated medical practitioner, who can return the call within 30 minutes.

Unacceptable after-hours coverage

- The office telephone is only answered during office hours;
- The office telephone is answered after-hours by a recording that tells patients to leave a
- message;
- The office telephone is answered after-hours by a recording that directs patients to go to
- an Emergency Room for any services needed; and
- Returning after-hours calls outside of 30 minutes.

Appointment Availability/Waiting Times for Appointments

The following schedule should be followed regarding appointment availability:

- **Routine** exams should be provided within 14 days of request.
- **Preventive** health services for children within 60 days
- **Preventive** health services for adults within 90 days
- **Urgent** care should be received within 24 hours of the request.
- **Emergency** care should be received immediately.
- **Referrals** to a specialist should be seen within 30 days of a request.

E. Referrals and Coordination of Care

Referral to Specialists

The PCP must assess the medical needs of Members and make medically necessary referrals to specialty care providers who are currently enrolled as participating provider with Molina Healthcare. If PCP believes that a Member needs to be referred to an Out-of Network provider, including medical partners not contracted with Molina, documentation demonstrating the need must be submitted to Molina Healthcare for review and prior authorization before referral can occur.

Members with disabilities, special health care needs, or chronic or complex conditions are allowed direct access to a specialist.

Coordination with Texas Department of Family & Protective Services

Molina works with TDFPS to ensure children in custody, or under the supervision, of TDFPS receive needed services. The needs of this population are special in that children will transition in and out of care more frequently than the general population.

Providers must:

- Coordinate with DFPS and Foster parents for the care of a child who is receiving services from, or has been placed in the conservatorship of DFPS and respond to requests from DFPS, including provide medical records to TDFPS;
- Schedule medical and Behavioral Health Services appointments within 14 days unless requested earlier by TDFPS; and
- Refer suspected abuse and neglect to TDFPS.

Molina must continue to provide all Covered Services to a Member receiving services from, or in the protective custody of TDFPS until the Member has been disenrolled from Molina due to loss of eligibility or placed into foster care.

Coordination and Referral to Other Health and Community Resources

The PCP must coordinate the care of Members with other Medicaid programs, public health agencies and community resources which provide medical, nutritional, educational, and outreach services to Members, including Women, Infants and Children Program (WIC), school health clinics, and local health and mental health departments.

F. Admissions for Inpatient Hospital Care

The Provider must maintain admitting privileges with a Molina participating hospital, or make arrangements with another Texas licensed physician who is an eligible Medicaid provider and who maintains admitting privileges with a participating Molina hospital. Providers can confirm Medicaid status of hospitals by contacting Texas Medicaid Health Partnership at 1-800-925-9126.

STAR+Plus Inpatient Services and Additional Benefits

STAR+PLUS members receive all the benefits of the traditional Texas Medicaid program; however, Molina is not responsible for paying providers for Inpatient Services. The provider must bill HHSC Claims Administrator for all Acute Care services. Molina's subcontracted Behavioral Health vendor, CompCare, is responsible for paying providers for the Behavioral Health Inpatient Services in the Harris Service Delivery Area effective June 1, 2007 and in the Bexar Service Delivery Area effective September

1, 2007. The provider must bill CompCare for Inpatient Behavioral Health Services. Additional benefits obtained through the STAR+PLUS program are:

- Annual Adult Well Checks
- Unlimited medically necessary prescription drugs for adults (available only to members who are not covered by Medicare)
- Value-Added Services
- Long-Term Care Covered Services

G. Fraud and Abuse

Providers are subject to all state and federal laws, regulations and rules which relate to the detection, investigation, and prosecution of fraud and abuse in health care and the Medicare and Medicaid programs. The Provider has a duty to take reasonable measures to detect and prevent fraud and abuse in the Provider's practice.

The Provider must cooperate with and assist HHSC and any state or federal agency charged with the duty of identifying, investigating, sanctioning or prosecuting fraud and abuse. The Provider must provide originals and/or copies of records and information requested and allow access to the premises and provide records to the Inspector General for the Texas Health and Human Services System, HHSC or its authorized agent(s), the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services (DHHS), the Federal Bureau of Investigation, TDI, or other units of state government. All copies of records must be provided free of charge at the time and place requested.

H. Confidentiality and HIPAA

Confidentiality

All Member information, records and data collected, or prepared by the Provider, or provided to the Provider by HHSC or another state agency is protected from disclosure by state and federal laws. The Provider must ensure that all information relating to Members is protected from disclosure except when the information is required to verify eligibility, provide services or assist in the investigation and prosecution of civil and criminal proceedings under state or federal law. The Provider must inform Members of their right to have their medical records and Medicaid information kept confidential.

The Provider must educate employees and Members concerning the human immunodeficiency virus (HIV) and its related conditions including acquired immunodeficiency syndrome (AIDS), and must develop and implement a policy for protecting the confidentiality of AIDS and HIV-related medical information and an anti-discrimination policy for employees and Members with communicable diseases. See also Health and Safety Code, Chapter 85, Subchapter E, relating to Duties of State Agencies and State Contractors.

HIPAA (Health Insurance Portability and Accountability Act) Requirements

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 Texas 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
    a. HIPAA
    b. Medicare and Medicaid laws

2. TX Medical Privacy 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 entity. (See, Sections 164.506(c)(2) & (3) of the HIPAA Privacy Rule.) 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:

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." (See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule.)

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; or
- 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.

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 both 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 advice

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 www.molinahealthcare.com for additional information.

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 itself 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.

J. Non-Discrimination

The Provider agrees to provide services to Molina Members on the same basis, at the same level, and the same quality as all other patients.

K. PCP Patient Capacity

There are no limitations on the number of patient's a PCP can have assigned to his/her practice; however, all PCP's reserve the right to state the number of patients they are willing to accept into their practice.

If a provider desires to make a change to his/her capacity, provider must contact the Provider Services Department. If the change request is received between the 1st and the 15th of the month, the change will be effective on the 1st day of the following month. If the change request is received after the 15th of the month, the change will be effective on the 1st day of the 2nd month following the request.

L. Medical Records

Providers must maintain confidential and complete medical records. Records must reflect all aspects of patient care, including ancillary services. Such records will enable providers to render the highest quality health care and enable Molina to review the quality and appropriateness of services.

Medical Record Keeping Practices

The following record keeping practices must be followed:

- Each patient has a separate medical record and pages are securely attached in the medical record.
- Medical records are organized with dividers.
- A chronic problem list is included in the record for all adults and children.
- Records are available at each encounter or are traceable.
- A complete health history is part of the record.
- Health maintenance forms include dates of preventive services.
- Medication sheets are complete and sample medications are documented.
- A system is in place to document missed appointments and phone messages.
- Advance Directives are discussed and documented for those over 18 years of age.
- Medical record retention is sufficient (at least 6 years).

Medical Record Documentation

A confidential medical record must be maintained for each Member that includes all pertinent information regarding medical services rendered. Providers must maintain established standards for accurate medical record keeping. Six categories have been designated as critical areas. These areas are:

- Problem lists
- Allergy designation
- Past medical history
- Working diagnosis consistent with findings
- Plans of action/treatment consistent with diagnosis
- Care medically appropriate

Providers must demonstrate 85% overall compliance in medical record documentation and 85% in each of the six critical categories. Molina uses the guidelines below when evaluating medical record documentation.

- A completed problem list is in a prominent space. Any absence of chronic/significant problems must be noted.
- Allergies are listed on the front cover of the record or prominently in the inside front page. If the patient has no known allergies, this is appropriately noted.
- A complete medical history is easily identified for patients seen three or more times. For children under seven (7) years of age, this includes source of history, family medical history, family social history, prenatal care and summary of birth events, developmental history, allergies, medication history, lead exposure, tobacco exposure, safety practices, serious accidents, operations and illnesses.
- A working diagnosis is recorded with the clinical findings. SOAP charting is recommended but not mandatory when progress notes are written.
- The plan of action and treatment is documented for the diagnosis.

- There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
- Patient name and identifying number is on each page of the record.
- The registration form or computer printout contains address, home, and work phone numbers, employer, gender and marital status. An emergency contact should also be designated.
- All staff and Provider notes are signed with initials or first initial, last name and title.
- All entries are dated.
- The record is legible to someone in the office other than the Provider. Dictation is preferred.
- There is an appropriate notation concerning tobacco exposure for children of all ages and the use of alcohol, tobacco, and substance abuse for patients 12 years old and older. Query history of the abuse by the time the patient has been seen three or more times.
- Pertinent history for presenting problem is included.
- Record of pertinent physical exam for the presenting problem is included.
- Lab and other studies are ordered as appropriate.
- There are notations regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or as needed. Include the preventive care visit when appropriate.
- Previous unresolved problems are addressed in subsequent visits.
- Evidence of appropriate use of consultants. This is reviewed for under and over utilization.
- Notes from consultants are in the record.
- All reports show initials of practitioner who ordered them.
- All consult and abnormal lab/imaging results show explicit follow-up plans.
- There is documentation of appropriate health promotion and disease prevention education. Anticipatory guidance is documented at each well child check.
- An immunization record and appropriate history of immunizations have been made for both children and adults.
- Preventive services are appropriately used/offered in accordance with accepted practice guidelines.

Medical Record Confidentiality

Molina Members have the right to full consideration of their privacy concerning their medical care. They are also entitled to confidential treatment of all Member communications and records. Case discussion, consultation, examination, and treatments are confidential and should be conducted with discretion. Written authorization from the Member or his/her authorized legal representative must be obtained before medical records are released to anyone not directly connected with his/her care, except as permitted or required by law.

Confidential Information is defined as any form of data, including but not limited to, data that can directly or indirectly identify individual Members by character, conduct, occupation, finances, credit, reputation, health, medical history, mental or physical condition, or treatment. Conversations, whether in a formal or informal setting, e-mail, faxes and letters are also potential sources of Confidential Information.

All participating Providers must implement and maintain an office procedure that will guard against disclosure of any Confidential Information to unauthorized persons. This procedure should include:

- Written authorization obtained from the Member or his/her legal representative before medical records are made available to anyone not directly connected with his/her care, except as permitted or required by law.
- All signed authorizations for release of medical information received must be carefully reviewed for any limitations to the release of medical information.
- Only the portion of the medical record specified in the authorization should be made available to the requestor and should be separated from the remainder of the Member's medical records.
- Notification to Molina of change in client condition, physical or eligibility

M. Second Opinions

Members or Member's PCP can request a second opinion on behalf of the Member. If you or a Member request a second opinion, Molina will give you a decision within 48 hours. If it is an imminent and serious threat, Molina will respond within one (1) day and the second opinion will be given within seventy-two (72) hours. If a qualified Participating Provider is not available to give the Member a second opinion, Molina will make arrangements for a Non-Participating Provider to give them a second opinion. If Molina denies the second opinion because it is not medically necessary, we will send the Member a letter. Members or Provider's may appeal the decision. The letter from Molina will tell you how to appeal.

N. Advance Directives

An advance directive is a formal document, written in advance of an incapacitating illness or injury, in which one can assign decision-making for future medical needs and treatments. Any provider delivering care to a Molina Member must ensure Members receive information on Advance Directives and are informed of their right to execute Advance Directions. Providers must document such information on the permanent medical record. Advance Directive forms may be found in the Appendix of this manual.

O. Routine, Urgent and Emergent Services

Definitions

Routine Services means health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent.

Severely disabled means that the Member's physical condition limits mobility and requires the client to be bed-confined at all times or unable to sit unassisted at all times, or requires continuous life-support systems (including oxygen or IV infusion) or monitoring of unusual physical or chemical restraint.

Urgent Services means services for a health condition, including an Urgent Behavioral Health Situation, which is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical evaluation or

treatment within 24 hours by the Member's PCP or PCP designee to prevent serious deterioration of the Member's condition or health.

Urgent Behavioral Health Situation means a behavioral health condition that requires attention and assessment within 24 hours but which does not place the Member in immediate danger to themselves or others and the Member is able to cooperate with treatment.

Emergency Behavioral Health Condition (for Medicaid only) means any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine:

- requires immediate intervention and/or medical attention without which a patient would present an immediate danger to himself or herself or others, or
- which renders the patient incapable of controlling, knowing or understanding the consequences of his or her actions.

Emergency Care Services (for CHIP only) means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the patient's health in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part;
- serious disfigurement; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

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

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

Emergency Services (for Medicaid only) means covered inpatient and outpatient services (1) furnished by an in-network or out-of-network provider that is qualified to furnish the services and (2) that are needed to evaluate or stabilize an Emergency Medical Condition and/or Emergency Behavioral Health Condition.

Emergency Prescription Supply

A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to non-preferred drugs on the Preferred Drug List and any drug that is affected by a clinical or PA edit and would need prescriber prior approval.

Emergency Transportation

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

Examples of conditions considered for emergency transports include, but are not limited to, acute and severe illnesses, untreated fractures, loss of consciousness, semi-consciousness, having a seizure or receiving CPR during transport, acute or severe injuries from auto accidents, and extensive burns.

Non-Emergency Transportation – Medical Transportation

When a client has a medical problem requiring treatment in another location and has no means of transportation, non-emergency service is covered. Non-emergency transports for a Medicaid client **must** be authorized prior to use.

Severely disabled means that the Member's physical condition limits mobility and requires the client to be bed-confined at all times or unable to sit unassisted at all times, or requires continuous life-support systems (including oxygen or IV infusion) or monitoring of unusual physical or chemical restraint.

A round-trip transport from the Member's home to a scheduled medical appointment is a covered service when the client meets the definition of severely disabled. All non-emergency ambulance transfers to a scheduled doctor's appointment require the doctor's name and address, the diagnosis, and treatment rendered at the time of visit.

P. Member Billing Practices

Member Acknowledgement Statement

A provider may bill the following to a Member without obtaining a signed Member Acknowledgment Statement:

- Any service that is not a benefit under Molina's Program (for example, personal care items).
- The provider accepts the Member as a private pay patient. Providers must advise Members that they are accepted as private pay patients at the time the service is provided and is responsible for paying for all services received. In this situation, HHSC strongly encourages the provider to ensure that the Member signs written notification so there is no question how the Member was accepted. Without written, signed documentation that the Medicaid Member has been properly notified of the private pay status, the provider does not seek payment from an eligible Medicaid Member.
- The Member is accepted as a private pay patient pending Medicaid eligibility determination and does not become eligible for Medicaid retroactively. The provider is allowed to bill the Member as a private pay patient if retroactive eligibility is not granted. If the Member becomes eligible

retroactively, the Member notifies the provider of the change in status. Ultimately, the provider is responsible for filing timely Medicaid claims. If the Member becomes eligible, the provider must refund any money paid by the Member and file Medicaid claims for all services rendered.

A provider attempting to bill or recover money from a Member in violation of the above conditions may be subject to exclusion from Molina.

In accordance with current federal policy, Members cannot be charged for the Member's failure to keep an appointment. Only billings for services provided are considered for payment. Members may not be billed for the completion of a claim form, even if it is a provider's office policy.

Private Pay Form Agreement

A private pay form agreement allows for a reduction in payment by a provider to a Member due to a medically needy spend down (effective September 1, 2003, the MNP is limited to children younger than age 19 years and pregnant women). If a provider accepts a Member as a private pay patient, the Provider **must** advise Members that they are accepted as private pay patients at the time the service is provided and is responsible for paying for all services received. In this situation, HHSC strongly encourages the provider to ensure that the Member signs written notification so there is no question how the Member was accepted. Without written, signed documentation that the Medicaid Member has been properly notified of the private pay status, the provider does not seek payment from an eligible Medicaid Member.

There are instances in which the Member is accepted as a private pay patient and a provider may bill a member. This is acceptable, if the provider accepts the patient and informs the member at the time of service that they will be responsible for paying for all services. In this situation, it is recommended that the provider use a Private Pay Form. The provider is allowed to bill the Member as a private pay patient if retroactive eligibility is not granted. If the Member becomes eligible retroactively, the Member notifies the provider of the change in status. Ultimately, the provider is responsible for filing timely Medicaid claims. If the Member becomes eligible, the provider must refund any money paid by the Member and file Medicaid claims for all services rendered.

SAMPLE

Private Pay Agreement Form
Member Acknowledgment Statement

"I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under Molina Healthcare of Texas as being reasonable and medically necessary for my care. I understand that HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

"Comprendo que, según la opinión del (nombre del proveedor), es posible que Medicaid no cubra los servicios o las provisiones que solicité (fecha del servicio) por no considerarlos razonables ni médicamente necesarios para mi salud. Comprendo que Molina Healthcare de Texas o su agente de seguros de salud determina la necesidad médica de los servicios o de las provisiones que el miémbro solicite o reciba. También comprendo que tengo la responsibilidad de pagar los servicios o provisiones que solicité y que reciba si después se determina que esos servicios y provisiones no son razonables ni médicamente necesarios para mi salud."

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Member Signature **Date**