Provider Manual

ICP (Integrated Care Program)

Molina Healthcare

Of Illinois, Inc.

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

Dear Provider:

I would like to extend a personal welcome to Molina Healthcare of Illinois, Inc. (Molina Healthcare) Enclosed is your Molina Healthcare Provider Manual, written specifically to address the requirements of delivering health care services to Molina Medicaid members.

This manual is designed to provide you with assistance in all areas of your practice, from making referrals to receiving payment for your services. In some cases, you may have developed internal procedures that meet the standards set out in this manual. In these instances you do not need to change your procedures - as long as they adhere to the standards outlined in this manual.

Also included are samples of the forms needed to fulfill your obligations under your Molina Healthcare contract. The sample forms are included to illustrate what is needed for appropriate documentation.

From time to time we will need to update and revise this manual as our policies or regulatory requirements change. All changes will be sent to you as additions to or deletions from this manual. You simply need to replace old pages with the new ones.

Thank you for your active participation in the delivery of quality health care services to our members and we look forward to a long and mutually rewarding experience.

Sincerely,

Nancy Wohlhart

Nancy Wohlhart
Vice President, Network Mgmt & Ops
Molina Healthcare of Illinois, Inc.

Molina Healthcare of Illinois, Inc. - Provider Manual

Section 1.

ADDRESSES AND PHONE NUMBERS

Member Services Department

The Member Services Department handles all telephone and written inquiries regarding member claims, benefits, eligibility/identification, selecting or changing Primary Care Providers (PCPs), and member complaints. Member Services Representatives are available 8:00 AM to 5:00 PM CST/CDT Monday through Friday, excluding State holidays.

Member Services	
Address:	Molina Healthcare of Illinois 1520 Kensington Rd., Suite 212 Oak Brook, IL 60523
Phone:	(855) 766-5462
TTY:	711

Claims Department

The Claims Department is located at our corporate office in Long Beach, CA. All hard copy (CMS-1500, UB-04) claims must be submitted by mail to the address listed below. Electronically filed claims must use Payor ID number 20934. To verify the status of your claims, please call our Provider Claims Representatives at the numbers listed below.

Claims	
Address	Molina Healthcare of Illinois PO Box 540 Long Beach, CA 90801
Phone:	(855) 866-5462

Credentialing Department

The Credentialing Department verifies all information on the Practitioner Application prior to contracting and re-verifies this information every three years. The information is then presented to the Professional Review Committee to evaluate a provider's qualifications to participate in the Molina Healthcare network.

Credentialing	
Address:	Molina Healthcare of Illinois Credentialing Department 8101 N. High St. Suite 370 Columbus, OH 43235
Phone:	(855) 866-5462
Fax:	(614) 781-4361

24-Hour Nurse Advice Line

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

HEALTHLINE (24-Hour Nurse Advice Line)	
Phone:	(888) 275-8750 English (866) 648-3537 Spanish
TTY:	(866) 735-2929 (English) (866) 833-4703 (Spanish)

Healthcare Services (Utilization Management) Department

The Utilization Management (UM) Department conducts concurrent review on inpatient cases and processes Prior Authorization requests. The UM Department also performs Case Management for members who will benefit from Case Management services. See the Prior Authorization Guide for specific phone numbers.

Utilization Management, Case Management Authorizations & Inpatient Census	
Address:	Molina Healthcare of Illinois 1520 Kensington Rd., Suite 212 Oak Brook, IL 60523
Phone:	(800) 594-7404
Fax:	(866) 617-4971

Health Education & Health Management Department

The Health Education and Health Management Department provides education and health information to Molina Healthcare members and facilitates provider access to the programs and services.

Health Education & Management	
Address:	Molina Healthcare of Illinois 1520 Kensington Rd., Suite 212 Oak Brook, IL 60523
Phone:	(888) 858-2156
Fax:	(630) 571-1220

Behavioral Health

Molina Healthcare of Illinois manages all components of behavioral health not offered directly through HFS for Molina Healthcare members. For member behavioral health needs, please contact us directly at:

Behavioral Health	
Address:	Molina Healthcare of Illinois 1520 Kensington Rd., Suite 212 Oak Brook, IL 60523
Phone:	(800) 594-7404
24 Hours per day, 365 day per year:	(888) 275-8750 English (866) 648-3537 Spanish

Pharmacy Department

Pharmacy services are covered by Molina Healthcare of Illinois. A list of in-network pharmacies is available on the Molinahealthcare.com website or by contacting Molina Healthcare's Customer Service Department at (855) 766-5462 or by fax at 800-961-5160.

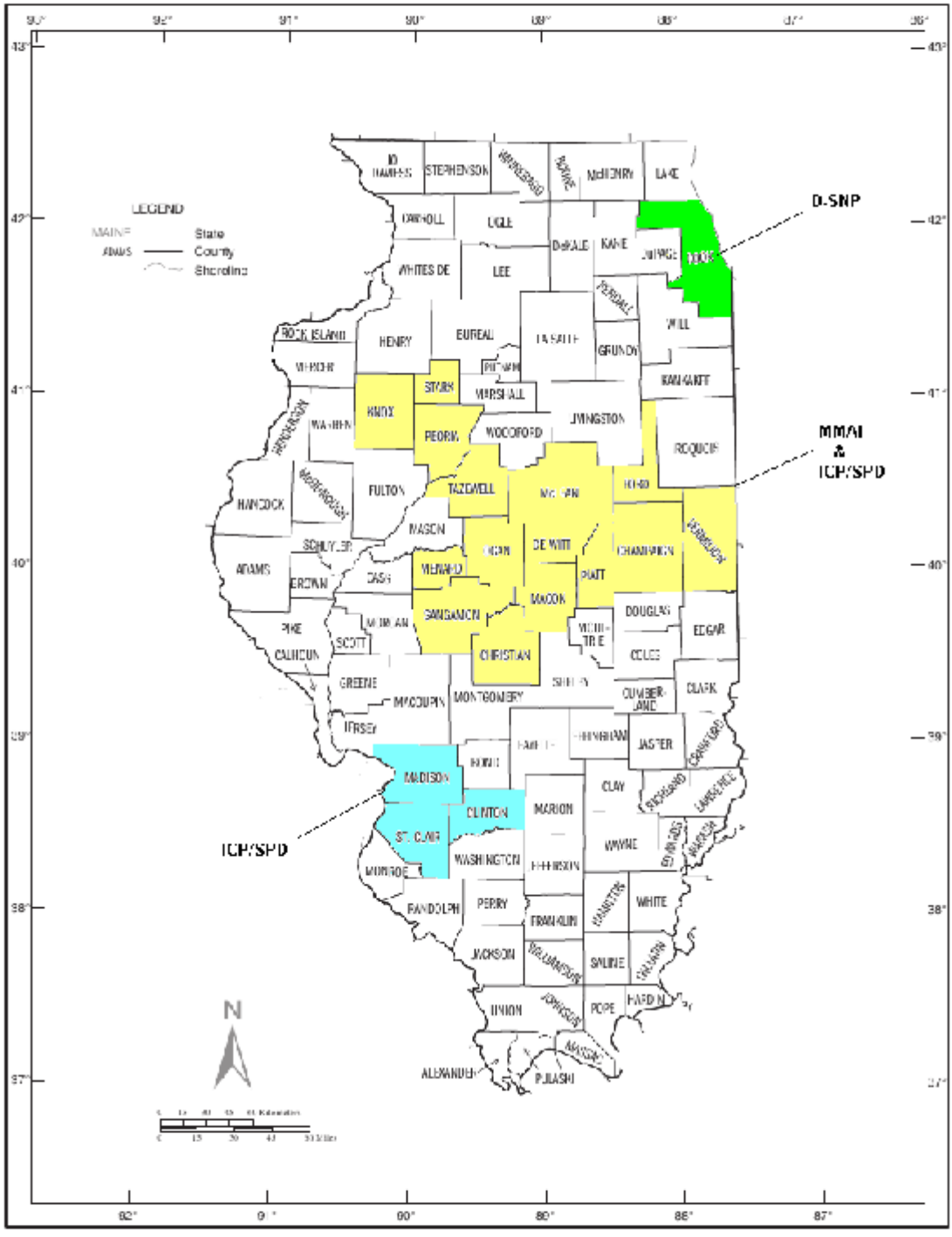
Provider Services Department

The Provider Services Department handles telephone and written inquiries from providers regarding address and Tax-ID changes, provider denied claims review, contracting, and training. The department has Provider Services Representatives serving all Molina Healthcare of Illinois' provider network.

Provider Services	
Address:	Molina Healthcare of Illinois 1520 Kensington Rd., Suite 212 Oak Brook, IL 60523
Phone:	(855) 866-5462
Fax:	(630) 571-1220

Molina Healthcare of Illinois, Inc. Service Area

Molina Healthcare of Illinois Service Areas



U.S. Census Bureau, Census 2000

Section 2.

ENROLLMENT, ELIGIBILITY AND DISENROLLMENT

Enrollment in Medicaid Programs

The Illinois Medical Assistance Program is the program which implements Title XIX of the Social Security Act (Medicaid). It is administered by the Illinois Department of Healthcare and Family Services (HFS) under the Illinois Public Aid Code. Under an interagency agreement with HFS, the Department of Human Services (DHS) acting through its agent the Illinois Client Enrollment Services (ICES) takes applications and determines the eligibility of individuals and families for the Medical Assistance Program.

Only Illinois Medical Assistance Program Recipients who are included in the eligible populations and living in counties with authorized Health Plans are eligible to enroll and receive services from Molina Healthcare. Molina Healthcare of Illinois participates in the Medical Assistance Program for Dual eligible members.

To enroll with Molina Healthcare, the member, member representative, or their responsible parent or guardian must complete and submit an application to DHS. This can be done by visiting the nearest DHS office, or where health reasons prohibit visiting an office, by contacting DHS to have an application mailed. Mailed applications will be followed-up by a telephone interview.

The Department of Human Services can be contacted at:

DHS Website: http://www.dhs.state.il.us/page.aspx

Toll Free at: 1-800-843-6154

TTY: 1-800-447-6404

The ICES can be contacted at:

ICES Website: http://www.enrollhfs.illinois.gov/Toll Free at: 1-877-912-8880:

TTY: 1-866-565-8576

DHS will enroll all eligible members with the health plan of their choice. If the member does not choose a plan, DHS will assign the member and their family to a plan that services the area where the member resides.

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

Effective Date of Enrollment

When initially applying for coverage, Medical Assistance applicants may request that their coverage is backdated to cover services they may have already received for up to three months prior to the month of their application.

Coverage shall begin as designated by HFS on the first day of a calendar month no later than three (3) calendar months from the date the enrollment is accepted by the Department's database.

HFS or its agent ICES will automatically re-enroll a member into the health plan in which he or she was most recently enrolled if the member has a temporary loss of eligibility, defined as less than sixty (60) calendar days.

Inpatient at Time of Enrollment

Regardless of what program or health plan the member is enrolled in at discharge, the program or plan the member is enrolled with on the date of admission shall be responsible for payment of all covered inpatient facility and professional services provided from the date of admission until the date the member is no longer confined to an acute care hospital.

Eligibility Verification

Medicaid Programs

HFS determines eligibility for the Medicaid Programs. Payment for services rendered is based on eligibility and benefit entitlement. The contractual agreement between providers and Molina Healthcare places the responsibility for eligibility verification on the provider of services.

Eligibility Listing for Medicaid Programs

Providers with a subscription can verify eligibility for Medicaid Program recipients by visiting the Medical Electronic Data Interchange (MEDI) system website at:

https://secure.myhfs.illinois.gov/login/AuthenticateUserRoamingEPF.html

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

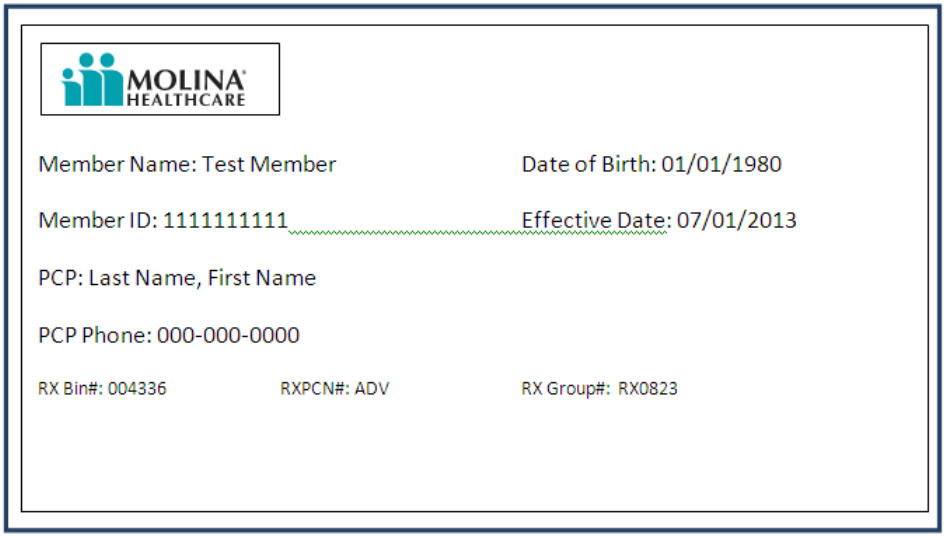
- Molina Healthcare Member Services at (855) 766-5462,
- Molina Healthcare Web Portal website, www.molinahealthcare.com, Provider Services

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

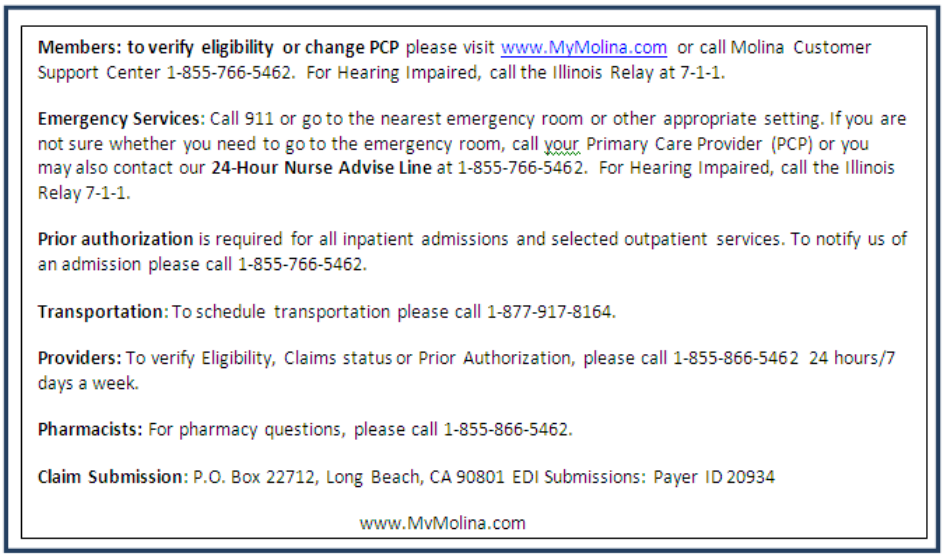
Identification Cards:

Molina Healthcare Sample Member ID card:

Card Front



Card Back



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

Disenrollment

Voluntary Disenrollment

Members have the right to request to change plans at any time. Members can change plans by calling Molina Healthcare Member Services at (855) 766-5462. Members requesting to disenroll from Molina Healthcare will be transferred to the ICES for education and assistance in selecting another health plan and PCP. Disenrollment can take four to six (4 to 6) weeks, and will be effective at 11:59 p.m. on the last day of the month following the month the disenrollment is processed by HFS.

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

Involuntary Disenrollment

Under very limited conditions and in accordance with HFS guidelines, members may be involuntarily disenrolled from a managed care program. With proper written documentation and approval by the HFS, the following are acceptable reasons for which Molina Healthcare may submit Involuntary Disenrollment requests to HFS or ICES:

- Member has moved out of the service area
- Member death
- Determination that the member is no longer eligible for coverage through Illinois Medical Assistance
- Fraudulent use of the member ID card(s)

PCP Dismissal

A PCP may dismiss a member from their practice based on standard policies established by the PCP. Reasons for dismissal must be documented by the PCP and may include:

- A member who continues not to comply with a recommended plan of health care. Such requests must be submitted at least sixty (60) calendar days prior to the requested effective date.

- A member whose behavior is disruptive, unruly, abusive or uncooperative to the extent that their Enrollment in the Health Plan seriously impairs the organization's ability to furnish services to either the member or other patients. This Section does not apply to members with mental health diagnoses if the member's behavior is attributable to the mental illness.

Missed Appointments

The provider will document and follow up on appointments missed and/or canceled by the member. Providers should notify Molina Healthcare when a member misses two (2) consecutive appointments. Members who miss three consecutive appointments within a six-month period may be considered for disenrollment from a provider's panel. Such a request must be submitted at least sixty (60) calendar days prior to the requested effective date. The provider agrees not to charge a member for missed appointments.

A member may only be considered for an involuntary disenrollment after the member has had at least one (1) verbal warning and at least one (1) written warning of the full implications of their failure of actions. The member must receive written notification at a sixth grade reading level from the PCP explaining in detail the reasons for dismissal from the practice. Action related to request for involuntary disenrollment conditions must be clearly documented by providers in the

member's records and submitted to Molina Healthcare. The documentation must include attempts to bring the member into compliance. A member's failure to comply with a written CAP must be documented. For any action to be taken, it is mandatory that copies of all supporting documentation from the member's file are submitted with the request. Molina Healthcare will contact the member to educate the member in the consequences of their behavior that is disruptive, unruly, abusive or uncooperative and/or assist the member in selecting a new PCP. The current PCP must provide emergency care to the member until the member is transitioned to a new PCP. HFS is the final approving authority for all disenrollment requests.

In the event a member appeals a disenrollment decision through the HFS appeals process, HFS may require the plan to continue to provide services to the member under the terms of the contract pending the final decision. The plan will continue to provide services either by the current PCP or by another medical practice. Should the member's behavior be a danger or threat to safety or the property of Molina Healthcare, its staff, providers, or other patients, Molina Healthcare will contact HFS to request an immediate involuntary disenrollment.

PCP Assignment

Molina Healthcare will offer each member a choice of PCPs. After making a choice, each member will have a single PCP. Molina Healthcare will assign a PCP to those members who did not choose a PCP at the time of Molina Healthcare selection. Molina Healthcare will take into consideration the member's last PCP (if the PCP is known and available in Molina Healthcare's contracted network), closest PCP to the member's home address, ZIP code location, and gender (OB/GYN). Molina Healthcare will assign all members that are reinstated after a temporary loss of eligibility of sixty (60) days or less to the PCP who was treating them prior to loss of eligibility, unless the member specifically requests another PCP, the PCP no longer participates in Molina Healthcare or is at capacity, or the member has changed geographic areas.

Molina Healthcare will allow pregnant members to choose the Health Plan's obstetricians as their PCPs to the extent that the obstetrician is willing to participate as a PCP. Molina Healthcare shall assign a pediatrician or other appropriate PCP to all pregnant members for the care of their newborn babies no later than the beginning of the last trimester of gestation. If Molina Healthcare was not aware that the member was pregnant until she presented for delivery, it will assign a pediatrician or a PCP to the newborn baby within one (1) business day after notification of birth. Providers shall advise all members of the members' responsibility to notify Molina Healthcare and HFS of their pregnancies and the births of their babies

PCP Changes

A member may change their PCP at any time with the change being effective no later than thirty-one (31) days following the member's request for the change. If the member is receiving inpatient hospital services at the time of the request, the change will be effective the first of the month following discharge from the hospital. The guidelines are as follows:

1. If a member calls to make a PCP change on or before the 15th of the month, the member will be effective with the new PCP on the first day of the next month.
2. If a member calls to change the PCP after the 15th of the month, the change will go into effect (30) days after the date the change was requested.
3. If the member was assigned to the incorrect PCP due to error by Molina Healthcare, the member can retroactively change the PCP, effective the first of the current month.

Section 3.

MEMBER RIGHTS AND RESPONSIBILITIES

This section explains the rights and responsibilities of Molina Healthcare members as written in the Member Handbook. Illinois law requires that health care providers or health care facilities recognize member rights while they 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 patients.

Below are the Member Rights and Responsibilities:

Molina Healthcare Member Rights & Responsibilities Statement

Members have the right to:

- To be treated with courtesy and respect, with appreciation of your individual dignity, and with protection of your need for privacy
- To a prompt and reasonable response to questions and requests
- To know who is providing medical services and who is responsible for your care
- To know what patient support services are available, including whether an interpreter is available if you do not speak English
- To know what rules and regulations apply to your conduct
- To be given by health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis
- To be able to take part in decisions about your health care, unless it is not in your best interest
- To have an open discussion about your medically necessary treatment options for your conditions, regardless of cost or benefit
- To refuse any treatment, except as otherwise provided by law
- To be given, upon request, full information and necessary counseling on the availability of known financial resources for your care
- To receive, upon request, prior to treatment, a reasonable estimate of charges for medical care
- To receive a copy of reasonably clear and understandable, itemized bill and, upon request, to have the charges explained
- To impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment
- To treatment for any emergency medical condition that will deteriorate from failure to provide treatment
- To know if medical treatment is for purposes of experimental research and to give your consent or refusal to participate in such experimental research
- To receive information about Molina Healthcare, its services, its practitioners and providers and members' right and responsibilities
- To make recommendations about Molina Healthcare's member rights and responsibilities policies
- To voice complaints or appeals about the organization or the care it provides
- To express grievance regarding any violation of your rights, as stated in Illinois law, through the grievance procedure of the health care provider or health care facility which you and to the appropriate state licensing agency listed below

Office of Civil Rights
United States Department of Health and Human Services
105 W. Adams, 16th Floor
Chicago, Illinois 60603
(312) 886-2359
(312) 353-5693 TTY

Illinois Department of Healthcare and Family Services
Bureau of Contract Management
Prescott E. Bloom Building
201 S. Grand Avenue East
Springfield, IL 62763
(217) 782-1200

Member Responsibilities:

- For providing to the health care provider, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to your health
- For reporting unexpected changes in your condition to the health care provider
- For reporting to the health care provider whether you comprehend a contemplated course of action and what is expected of you
- To follow the care plan that you have agreed on with your provider
- For keeping appointments and, when you are unable to do so for any reason, to notify the health care provider or healthcare facility
- For your actions if you refuse treatment or do not follow the health care provider's instructions
- For following health care facility rules and regulations affecting patient care and conduct
- To understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible

Second opinions

If a member does not agree with their provider's plan of care, they have the right to a second opinion from another provider. Members should call Member Services to find out how to get a second opinion.

Section 4.

BENEFITS AND COVERED SERVICES

This section provides an overview of the medical benefits and covered services for Molina Healthcare members.

There are no member co-pays associated with services provided through Molina Healthcare's coverage programs. Some benefits may have limitations. Please call the Member Services Department for addition information or for a complete list of benefits at (855) 766-5462.

Service Covered by Molina Healthcare:

- Alcohol and substance abuse treatment
- Audiology services
- Behavior health services
- Chiropractic services
- Contraceptive devices
- Dental Services
- Durable and non-durable medical equipment and supplies (DME)
- Emergency services
- Family Planning Services
- Health education
- Home health care services
- Hospice
- Hospital inpatient and outpatient services
- Immunizations
- Laboratory and x-ray services
- Mammograms
- Maternity care services
- Pharmacy Services
- Physician services
- Physical, occupational, and speech therapy
- Podiatry services
- Preventive services
- Private duty nursing
- Skilled nursing care
- Skilled nursing facility (first 90 days)
- Speech and language therapy
- Transplant services (non-experimental)
- Transportation
- Vision Services
- Whole blood and blood products
- X-ray services

Services Covered by Healthcare and Family Services (HFS):

- Skilled nursing facility (after 90 days)

Services Not Covered:

- Elective cosmetic surgery
- Custodial care cervices
- Elective abortions

- Infertility services

Prescription Drugs

Prescription drugs are covered through Molina Healthcare. A list of in-network pharmacies is available on the Molinahealthcare.com website or by contacting Molina Healthcare's Customer Service Department at (855) 766-5462.

A prescription limitation limits the member to four prescriptions every 30 days. Any additional prescriptions require prior approval by Molina. The limitation is not intended to deny members access to needed prescription drugs, it is intended to review a patient's entire medication regimen and where clinically appropriate, reduce duplication and unnecessary medication. The following classes of drugs do not require prior approval as a result of the four prescription policy: Oncolytics, Anit-Retroviral Agents, Contraceptives, Immunosuppressives, Over-the-counter drugs, Non-drug items such as blood glucose monitors and test strips.

Injectable and Infusion Services

Injectable products and all infusion drug requests require a Drug Evaluation Review (DER) and are supplied by Molina Healthcare's specialty pharmacy vendor. Specialty drugs require a DER and are not available through the retail pharmacy network.

Family planning services related to the injection or insertion of a contraceptive drug or device are covered.

Access to Behavioral Health Services

Members in need of behavioral health services can be referred by their PCP for services or members can self-refer by calling Molina Healthcare Behavioral Health Department at **(888) 858-2156.** Molina Healthcare is available twenty-four (24) hours a day, seven (7) days a week for behavioral health needs. The services members receive will be confidential. Additionally, members may access certain behavioral health services through programs and services offered through the Illinois Department of HFS.

Behavioral Health Services Include:

- Inpatient services
- Outpatient hospital services
- Psychiatric doctor services

These services require prior authorization.

Emergency Behavioral Health Services

Members are directed to call 911 or go to the nearest emergency room if they need emergency behavioral health services. Examples of emergency behavioral health problems are:

- Danger to self or others
- Not being able to carry out daily activities

- Things that will likely cause death or serious bodily harm

Out of Area Emergencies

Members having a behavioral health emergency who cannot get to a Molina Healthcare approved providers are directed to do the following:

- Go to the nearest hospital or facility
- Call the number on ID card
- Call member's PCP and follow-up within twenty-four (24) to forty-eight (48) hours

For out-of-area emergency care, plans will be made to transfer members to an in-network facility when member is stable.

Obtaining Behavioral Health Services

Members and providers should call Member Services or the Behavioral Health Department to find a behavioral health provider.

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 server injuries from auto accidents, and extensive burns.

Non-Emergency Medical Transportation

Molina Healthcare provides free transportation to the following:

- Scheduled doctor's appointments
- Pharmacy
- DME provider
- WIC Office

Non-Emergency transportation is provided through LogistiCare. If one of your patients is in need of this service please have them call LogistiCare directly at (877) 917-8164.

If your patient needs further assistance they can also call (855) 766-5462 and one of our Member Service Representatives will assist them with this request.

Non-emergency transportation services must have prior approval and all patients should call at least three (3) business days in advance of when the services are needed. These services require an authorization.

Home and Community Based Services

Certain Molina members are eligible for Home and Community Based Services depending on their Waiver eligibility. These services are coordinated through our Medical Management Program.

Service	Elderly	Disability	HIV/AIDS	Brain Injury
Adult Day Service	√	√	√	√
Adult Day Service Transportation	√	√	√	√
Environmental Modification		√	√	√
Supported Employment				√
Home Health Aide		√	√	√
Nursing, Intermittent		√	√	√
Nursing, Skilled		√	√	√
Occupational Therapy		√	√	√
Physical Therapy		√	√	√
Speech Therapy		√	√	√
Prevocational Services				√
Day Habilitation				√
Homemaker	√	√	√	√
Home Delivered Meals		√	√	√
Emergency Home Response System	√	√	√	√
Respite		√	√	√
Adaptive Equipment		√	√	√
Behavioral Services				√

Preventive Care

Immunizations

Adult members may receive immunizations as recommended by the Centers for Disease Control and Prevention (CDC) and prescribed by the member's PCP. Molina Healthcare covers immunizations.

We need your help conducting these regular exams in order to meet the Department of Healthcare and Family Services targeted state standard. If you have questions or suggestions related to well child care, please call our Health Education line at (888) 858-2156.

Prenatal Care (Normal Pregnancy)

Stage of Pregnancy	How often to see the doctor
1 month – 6 months	One (1) visit a month

7 months – 8 months	Two (2) visits a month
9 months	One (1) visit a week

24 Hour Nurse Advice Line

Members may call the Nurse Advise Line anytime they are experiencing symptoms or need health care information. Registered nurses are available twenty-four (24) hours a day, seven (7) days a week, to assess symptoms and help make good health care decisions.

HEALTHLINE (24-Hour Nurse Advice Line)	
Phone:	(888) 275-8750 (English) (866) 648-3537 (Spanish)
TTY:	(866) 735-2929 (English) (866) 833-4703 (Spanish)

Molina Healthcare is committed to helping our members:

- Prudently use the services of your office
- Understand how to handle routine health problems at home
- Avoid making non-emergent visits to the emergency room (ER)

The Nurse Advice Line registered nurses do not diagnose, they assess symptoms and guide the patient to the most appropriate level of care following specially designed algorithms unique to the Nurse Advice Line. The Nurse Advice Line may refer back to the PCP, a specialist, urgent care, ER, or 911. By educating patients, it facilitates appropriate use of the healthcare services.

Health Management Programs

Molina Healthcare wants you to be aware of health management programs offered to assist with care management. We have programs that can help you manage your patient's condition. These include programs, such as:

- Asthma
- Diabetes
- Cardiovascular Disease
- Congestive Heart Failure
- COPD

A Care Manager/Nurse is on hand to teach your patient's about their disease. He/she will manage the care with the member's assigned PCP and provide other resources. There are many ways a member is identified to enroll in these programs. One way is through medical or pharmacy claims. Another way is through Nurse Advice Line or doctor referral. Members can also ask Molina Healthcare to enroll them. It is the member's choice to be in these programs. A member can choose to disenroll from the program at any time.

For more info about our health management programs, please call:

Member Services Department at (855) 766-5462

TTY at 711

Visit www.molinahealthcare.com

Molina Healthcare health management programs provide patient education information to members and facilitate provider access to these chronic disease programs and services.

a. Program Eligibility Criteria and Referral Source

Health management programs are designed for Molina Healthcare members with a confirmed diagnosis. Members participate in programs for the duration of their eligibility with the plan's coverage or until the member opts out. Each identified member will receive specific educational materials and other resources in accordance with their assigned stratification level. Additionally, all identified members will receive regular educational newsletters. The program model provides an "opt-out" option for members who contact Molina Healthcare Member Services and request to be removed from the program.

Multiple sources are used to identify the total eligible population. These may include the following:

- Pharmacy claims data for all classifications of medications
- Encounter data or paid claim with a relevant CPT-4 or ICD-9 code
- Member Services welcome calls made by staff to new member households and incoming member calls have the potential to identify eligible program participants. Eligible members are referred to the program registry
- Practitioner/provider referral
- Nurse Advice Line referral
- Medical Case Management or Utilization Management
- Member self-referral due to general plan promotion of program through member newsletter, the Nurse Advice Line or other member communication.

b. Practitioner/Provider Participation

Contracted practitioners/providers are automatically notified whenever their patients are enrolled in a health management program. Practitioner/provider resources and services may include:

- Annual practitioner/provider feedback letters containing a list of patients identified with the relevant disease
- Clinical resources such as patient assessment forms and diagnostic tools
- Patient education resources
- Provider newsletters promoting the health management programs, including how to enroll patients and outcomes of the programs

- Clinical Practice Guidelines
- Preventive Health Guidelines

Additional information on health management programs is available from your local Molina Healthcare QI Department toll free at (888) 858-2156.

Pregnancy Health Management Program

We care about the health of our pregnant members and their babies. Molina's pregnancy program will make sure member and baby get the needed care during the pregnancy. You can speak with trained Nurses and Care Managers. They can give your office/member the support needed and answer questions you may have. You will be mailed a workbook and other resources are available. The member will also learn ways to stay healthy after child birth. Special care is given to those who have a high-risk pregnancy. It is the member's choice to be in the program. They can choose to be removed from the program at any time. Molina Healthcare is requesting your office to complete the pregnancy notification form (refer to appendix B for form) and return to us as soon as pregnancy is confirmed.

Although pregnancy itself is not considered a disease state, a significant percentage of pregnant females on Medicaid are found to be at moderate to high-risk for a disease condition for the mother, the baby or both. The Motherhood Matters [SM] pregnancy management program strives to reduce hospitalizations and improve birth outcome through early identification, trimester specific assessment and interventions appropriate to the potential risks and needs identified. The Motherhood Matters [SM] program does not replace or interfere with the member's physician assessment and care. The program supports and assists physicians in the delivery of care to members.

Motherhood Matters [SM] Program Activities:

Motherhood Matters [SM] Pregnancy Health management Program encompasses clinical case management, member outreach and member and provider communication and education. The Prenatal Case Management staff works closely with the provider community in identification, assessment, and implementation of appropriate intervention(s) for every member participating in the program. The program activities include early identification of pregnant members, early screening for potential risk factors, provision of telephonic and written trimester appropriate education to all pregnant members and families, referral of high-risk members to prenatal case management, and provision of assessment information to physicians.

- Prenatal Case Management – Members assessed to be high risk are contacted via telephone for further intervention and education. A care plan is developed and shared with the physician to ensure that all educational and care needs are met. Prenatal case management registered nurses, in conjunction with the treating physician, coordinate health care services, including facilitation of specialty care referrals, coordination of home health care and DME service and referral to support groups or community social services. The case management data base generates reminders for call backs for specific assessments, prenatal visits, postpartum visits and well-baby checkups.
- Smoking Cessation – For information about the Molina Smoking Cessation Program or to enroll members, please contact our Health Management Unit.
- Member Outreach – Motherhood Matters [SM] Program is promoted to members through various means including, program brochures in new member Welcome Packets, other member mailings, Member Newsletters, Provider Newsletters, posters and brochures placed in practitioner's offices and marketing materials and collaboration with national and local community-based entities.

breathe with ease

Molina Healthcare provides an asthma health management program called *breathe with ease*, designed to assist members in understanding their disease. Molina Healthcare has a special interest in asthma, as it is the number one chronic diagnosis for our members. This program was developed with the help of several community providers with large asthma populations. The program educates the member and family about asthma symptom identification and control. Our goal is to partner with you to strengthen asthma care in the community.

***breathe with ease* Program Activities:**

The first component of our program provides general asthma education to all identified asthma members, including an asthma newsletter. Our goal is to provide members with a basic understanding of asthma and related concepts, such as common triggers. We also encourage members to see their PCP regularly for asthma status checks, and important preventive and well-child care.

The second component of our program offers members identified as having high needs an opportunity to enroll in our more intensive asthma program. We identify these members through claims and pharmacy data, with a specific focus on ER utilization and inpatient admissions for asthma.

Additional Asthma Program Benefits:

- Clinical Practice Guidelines – Molina Healthcare adopted the NHLBI Asthma Guidelines
- Asthma Registry – Molina Healthcare established an asthma registry. The registry uses available claims and pharmacy information to identify and track asthma members in the program
- Asthma Newsletters – Molina Healthcare distributes asthma newsletters to identified members
- Care Reminders and Age-Appropriate Tools – Molina Healthcare provides individualized reminders and educational tools to members with asthma
- Asthma Education – Asthma education is covered for all Molina Healthcare members. We encourage providers to refer patients to these services, especially for newly diagnosed asthmatics or those having difficulty managing their disease
- Smoking Cessation – For information about the Molina Healthcare smoking cessation program or to enroll members, please contact our Health Management Unit

Asthma Profiles – We send PCPs a report or profile of patients with asthma. This shows specific patient utilization information of medication use, emergency department visits, and hospitalizations. We also request the PCP provide us with the names of Molina Healthcare asthma patients not included in the profile.

Healthy Living with Diabetes

Molina Healthcare's *Healthy Living with Diabetes* health management program is a collaborative team approach comprised of patient education, clinical case management and provider education. The team works closely with contracted practitioners in the identification,

assessment and implementation of appropriate interventions for non-pregnant adults diagnosed with diabetes.

The Healthy Living with Diabetes Program Includes:

- Clinical Practice Guidelines – Molina Healthcare adopted the American Diabetes Association (ADA) guidelines for diabetic care

- Diabetes Registry – Molina Healthcare established a diabetes registry. The registry uses available claims and pharmacy information to identify and track diabetic members in the program

- Diabetes Newsletters – Molina Healthcare distributes newsletters to diabetic members

- Care Reminders and Age-Appropriate Tools – Molina Healthcare provides individualized reminders and educational tools to members with diabetes

- Diabetes Education – Diabetes education is covered for all Molina Healthcare members. We encourage providers to refer patients to these services, especially for newly diagnosed diabetics or those having difficulty managing their disease

- Smoking Cessation – For information about the Molina HealthCare's smoking cessation program or to enroll members, please contact our Health Management Unit

Diabetes Profiles – We will send the PCP a report or profile of patients with diabetes. This shows specific patient utilization information of medication use, emergency department visits, and hospitalizations. We also request the PCP provide us with the names of Molina Healthcare diabetic patients not included in the profile.

To find out more information about the health management programs, please call Member Services Department at (855) 766-5462.

Heart Healthy Living

Molina Healthcare's *Heart Healthy Living* health management program is a collaborative team approach comprised of patient education, clinical case management and provider education. The team works closely with contracted practitioners in the identification, assessment and implementation of appropriate interventions for members with cardiovascular disease (CVD).

While CVD can encompass many different conditions that often co-exist, Molina Healthcare has chosen to target three subprograms: heart failure, coronary artery disease (CAD) and hypertension. The literature supports the selection of these three conditions as being responsive to interventions aimed at the development of adequate self-management skills in optimizing clinical outcomes and improving quality of life.

The *Heart Healthy Living* – Cardiovascular Disease (CVD) Management Program includes:

- Clinical Practice Guidelines – Molina Healthcare adopted the National Heart, Lung and Blood Institute (NHLBI) and the American Heart Association guidelines for cardiovascular care

- Cardiovascular Disease Registry – Molina Healthcare established a CVD registry. The

registry uses available claims and pharmacy information to identify and track cardiovascular members in the program

- Cardiovascular Disease Newsletters – Molina Healthcare distributes newsletters to CVD members

- Care Reminders and Tools – Molina Healthcare provides individualized reminders and educational tools to members with CVD

- Cardiovascular Disease Education – CVD education is covered for all Molina Healthcare members. We encourage providers to refer patients to these services, especially for newly diagnosed heart disease or those having difficulty managing their disease

- Smoking Cessation – For information about the Molina Healthcare smoking cessation program or to enroll members, please contact our Health Management Unit

CVD Profiles – We will send the PCP a report or profile of patients with heart disease. This shows specific patient utilization information of medication use, emergency department visits, and hospitalizations. We also request the PCP provide us with the names of Molina Healthcare CVD patients not included in the profile.

To find out more information about the health management programs, please call Member Services Department at (855) 766-5462.

Healthy Living with COPD

Given the diversity of Molina Healthcare's membership a health management system created around COPD should improve the quality of life among our members and clinical outcomes in the future. Molina Healthcare's *Healthy Living with COPD* disease management program strives to improve outcomes through continual, rather than episodic, care. The program provides the most intense follow-up with members at the greatest risk for poor outcomes. Providing a continuum of coordinated, comprehensive care reduces the incidence of acute episodes requiring emergency treatment and promotes improved quality of care for our members.

The *Healthy Living with COPD* Program Includes:

- Clinical Practice Guidelines – Molina Healthcare adopted the Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines for COPD care

- COPD Registry – Molina Healthcare established a COPD registry. The registry uses available claims and pharmacy information to identify and track COPD members in the program

- COPD Newsletters – Molina Healthcare distributes newsletters to COPD members

- Care Reminders and Appropriate Tools – Molina Healthcare provides individualized reminders and educational tools to members with COPD

- COPD Education – COPD education is covered for all Molina Healthcare members. We encourage providers to refer patients to these services, especially for newly diagnosed members or those having difficulty managing their disease

- Smoking Cessation – For information about the Molina Healthcare smoking cessation program or to enroll members, please contact our Health Management Unit

COPD Profiles – We will send the PCP a report or profile of patients with COPD. This shows specific patient utilization information of medication use, emergency department visits, and hospitalizations. We also request the PCP provide us with the names of Molina Healthcare COPD patients not included in the profile.

To find out more information about the health management programs, please call Member Services Department at (855) 766-5462.

Section 5.

TRANSPORTATION

Non-Emergency Medical Transportation

Molina Healthcare provides non-emergency medical transportation through our vendor, Logisticare.

If one of your patients is in need of this service please have them call LogistiCare directly at (877) 917-8164.

If your patients' needs further assistance they can also call (855) 766-5462 and one of our Member Service Representatives will assist them with this request.

Non-emergency transportation services must have prior approval and all patients should call at least forty-eight (48) hours before the services are needed. These services require an authorization.

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 server injuries from auto accidents, and extensive burns.

Section 6.

PROVIDER RESPONSIBILITIES

This section describes Molina Healthcare's established standards on access to care, newborn notification process, and member marketing information for participating providers. In applying the standards listed below, participating providers have agreed they will not discriminate against any member on the basis of:

- Age
- Race
- Creed
- Color
- Religion
- Sex
- National origin
- Ancestry
- Sexual orientation
- Marital status
- Physical disability
- Mental or sensory handicap
- Place of residence
- Socioeconomic status
- Status as a recipient of Medicaid benefits

Additionally, participating providers or contracted medical groups/IPAs may not limit their practices because of a member's medical (physical or mental) condition or the expectation for the need of frequent or high cost care. If PCPs choose to close their panel to new members, Molina Healthcare must receive thirty (30) days advance notice from the provider.

Access to Care Standards

Molina Healthcare is committed to providing timely access to care for all members in a safe and healthy environment. Molina Healthcare will ensure providers offer hours of operation no less than offered to commercial members. Access standards have been developed to ensure that all health care services are provided in a timely manner. The PCP or designee must be available twenty-four (24) hours a day, seven days a week to members for emergency services. This access may be by telephone. Appointment and waiting time standards are shown below. Any

member assigned to a PCP is considered their patient.

For additional information about how Molina Healthcare audits access to care, please refer to Section 8 (Quality Improvement) of this manual.

Primary Care Practitioner (PCP)	
Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Emergency Care	Immediate
Preventive Care Appointment	Within five (5) weeks of request
Routine Care	Within three (3) weeks of request
Urgent	Within twenty-four (24) hours (Serious problem, not deemed Emergency Care)
After Hours Care	After-Hours Instruction/Standards
After hours emergency instruction	If this is an emergency, please hang up and dial 911
After-Hours Care	Available by phone twenty-four (24) hours/seven (7) days
Prenatal Care	
Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Initial Appointment: First Trimester	Within two (2) weeks of request
Initial Appointment: Second Trimester	Within one (1) week of request
Initial Appointment: Third Trimester	Within three (3) days of request
Behavioral Health	
Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Non-life Threatening Emergency Care	Within ≤ six (6) hours of request
Urgent Care	Within ≤ twenty-four (24) hours of request
Routine Care	Within ≤ ten (10) working days of request

Relocations and Additional Sites

Providers should notify Molina Healthcare sixty (60) days in advance when they relocate or open an additional office. When this notification is received, a site review of the new office may be conducted before the provider's recredentialing date.

Site and Medical Record-Keeping Practice Reviews

As a part of Molina Healthcare's Quality Improvement (QI) program, providers are required to maintain compliance with certain standards for safety, confidentiality, and record keeping practices in their practices. For details regarding these requirements and other QI program expectations please refer to Section 8 of this manual.

Member Information and Marketing

Any written informational and marketing materials directed at Molina Healthcare members must be developed at a sixth grade reading level and have prior written consent from Molina Healthcare and the appropriate government agencies. Please contact your Provider Services Representative for information and review of proposed materials. Neither Molina Healthcare, nor any contracted providers nor medical groups/IPA may:

- Distribute to its members informational or marketing materials that contain false or misleading information
- Distribute to its members marketing materials selectively within the service area
- Directly or indirectly conduct door-to-door, telephonic, or other cold-call marketing for member enrollment

Section 7.

MEDICAL MANAGEMENT

Molina Healthcare providers must ensure members receive medically necessary health care services in a timely manner without undue interruption. The member's PCP is responsible for:

- Providing routine medical care to Molina Healthcare members
- Following up on missed appointments
- Prescribing diagnostic and/or laboratory tests and procedures
- Coordinating Referrals and obtaining Authorization when required

This section on Referrals, Authorizations, and Healthcare Services (HCS) describes procedures that apply to directly contracted Molina Healthcare PCPs. All contracted providers must obtain Molina Healthcare's Authorization for specific services that require approval.

Healthcare Services (Utilization Management)

Prospective review is a process performed by the Healthcare Services staff to evaluate requests for specified services or procedures. Determinations are made by specially trained personnel based on medical necessity and appropriateness, and reflect the application of Molina Healthcare's approved review criteria and guidelines. Any denial of services may only be issued by the Medical Director (including for services denied because of benefit limitations) or their designee.

Referral versus Prior Authorization

Referral: An authorization from Molina Healthcare is not required to refer a patient to a contracted specialist. In referring a patient, the PCP should forward pertinent patient

information/findings to the Specialist.

Authorization: Generally, authorization requirements are designed to assure the medical necessity of service, prevent unanticipated denials of coverage, ensure participating providers are utilized and all services are provided at the appropriate level of care for the member's needs.

Providers should send requests for authorizations to the Utilization Management Department by phone or fax. Providers may also submit authorization requests through Molina Healthcare's Web Portal at www.molinahealthcare.com. Contact information is listed below.

Phone:	(885) 866-5462
Fax:	(866) 403-8299

Providers are encouraged to use the Molina Healthcare Prior Authorization Request Form (included at the end of this section). If using a different form, the provider is required to supply the following information, as applicable, for the requested service:

- Member demographic information (name, date of birth, social security number, etc.)
- Provider demographic information (referring provider and referred specialist)
- Requested service/procedure, including specific **CPT/HCPCS Codes**
- Member diagnosis (**ICD-9 Code and description**)
- Clinical indications necessitating service pertinent medical history and treatment, laboratory data, and/or physical exams that address the area of request
- Location where the service will be performed
- Requested length of stay (inpatient requests)

Pertinent data and information is required by the Healthcare Services (HCS) staff to enable a thorough assessment for medical necessity and to verify that the diagnosis and procedure codes included in the Prior Authorization Request are appropriate and are incorporated into the Authorization. Authorization is based on medical necessity as well as member eligibility and benefit coverage at the time of service. Molina Healthcare will process any non-urgent requests within fourteen (14) calendar days of receipt of request. Urgent requests will be processed within seventy- two (72) hours. Information generally required to support the decision-making process includes:

- Adequate patient history related to the requested services
- Physical examination that addresses the area of the request
- Supporting lab and/or X-ray results to support the request
- Relevant PCP and/or Specialist progress notes or consultations
- Any other relevant information or data specific to the request

Providers who request Authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting provider at (888) 858-2156.

Avoiding Conflict of Interest

The HCS Department affirms its decision-making is based on appropriateness of care and service and the existence of benefit coverage.

Molina Healthcare does not reward providers or other individuals for issuing denials of coverage or care. Furthermore, Molina Healthcare never provides financial incentives to encourage authorization decision makers to make determinations that result in under-utilization.

Also, we require our delegated medical groups/IPAs to avoid this kind of conflict of interest.

Coordination of Care

Molina Healthcare's Integrated Care Management, which includes Utilization Management, Case Management and Health Management will work with providers to assist with coordinating services and benefits for members with complex needs and issues. It is the responsibility of contracted providers to assess members and with the participation of the member and their representatives, create a treatment care plan. The treatment plan is to be documented in the medical record and is updated as conditions and needs change.

Molina Healthcare staff assists providers by identifying needs and issues that may not be verbalized by providers, assisting to identify resources such as community programs, national support groups, appropriate Specialists and facilities, identifying best practice or new and innovative approaches to care. Care coordination by Molina Healthcare staff is done in partnership with providers and members to ensure efforts are efficient and non-duplicative.

Continuity of Care and Transition of Members

Molina Healthcare members involved in an active course of treatment have the option to complete treatment with the provider who initiated care. The lack of a contract with the provider of a new member or terminated contracts between Molina Healthcare and a provider will not interfere with this option. This option includes members who are:

- Pregnant
- Receiving care for an acute medical condition
- Receiving care for an acute episode of a chronic condition

For each member identified in the categories above, Molina Healthcare will work with the treating provider on a transition plan over a reasonable period of time. Each case will be individualized to meet the member's needs.

Requests for continued care should be submitted to the HCS Department at the phone number and address listed at the beginning of this section. All requests will be reviewed by the Medical Director. Molina Healthcare generally will not approve continued care by a non-contracted provider if:

- The member only requires monitoring of a chronic condition
- The provider does not qualify for Molina Healthcare credentialing based on a previous professional review action
- The provider is unwilling to continue care for the member
- The provider has never seen the member prior to enrolling with Molina Healthcare

Continuity and Coordination of Provider Communication

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

Case Management

Molina Healthcare provides a comprehensive Case Management (CM) program to all members who meet the criteria for services. The CM program focuses on procuring and coordinating the care, services, and resources needed by members with complex issues through a continuum of care. Molina Healthcare adheres to Case Management Society of America Standards of Practice Guidelines in its execution of the program.

The Molina Healthcare case managers are licensed professionals and are educated, trained and experienced in the case management process. The CM program is based on a member advocacy philosophy, designed and administered to assure the member value-added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes.

The CM program is individualized to accommodate a member's needs with collaboration and approval from the member's PCP. The Molina Healthcare case manager will arrange individual services for members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina Healthcare case manager is responsible for assessing the member's appropriateness for the CM program and for notifying the PCP of the evaluation results, as well as making a recommendation for a treatment plan.

Referral to Case Management: Members with high-risk medical conditions may be referred by their PCP or specialty care provider to the CM program. The case manager works collaboratively with all members of the health care team, including the PCP, hospital UM staff, discharge planners, specialist providers, ancillary providers, the local Health Department and other community resources. The referral source provides the case manager with demographic, health care and social data about the member being referred.

Members with the following conditions may qualify for case management and should be referred to the Molina Healthcare CM Program for evaluation:

- High-risk pregnancy, including members with a history of a previous preterm delivery
- Catastrophic medical conditions (e.g. neoplasm, organ/tissue transplants)
- Chronic illness (e.g. asthma, diabetes, End Stage Renal Disease)
- Pre-term births
- High-technology home care requiring more than two weeks of treatment
- Member accessing ER services inappropriately

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

Phone: (855) 866-5462

Fax: (630) 571-1220

PCP Responsibilities in Case Management Referrals

The member's PCP is the primary leader of the health team involved in the coordination and direction of services for the member. The case manager provides the PCP with reports, updates, and information regarding the member's progress through the case management plan. The PCP is responsible for the provision of preventive services and for the primary medical care of members.

Case Manager Responsibilities

The case manager collaborates with all resources involved and the member to develop a plan of care which includes a multidisciplinary action plan (team treatment plan), a link to the appropriate institutional and community resources, and a statement of expected outcomes. Jointly, the case manager, providers, and the member are responsible for implementing the plan of care. Additionally the case manager:

- Monitors and communicates the progress of the implemented plan of care to all involved resources
- Serves as a coordinator and resource to team members throughout the implementation of the plan, and makes revisions to the plan as suggested and needed
- Coordinates appropriate education and encourages the member's role in self-help
- Monitors progress toward the member's achievement of treatment plan goals in order to determine an appropriate time for the member's discharge from the CM program

Health Education and Health Management Programs

Molina Healthcare's Health Education and Health Management programs will be incorporated into the member's treatment plan to address the member's health care needs. Primary prevention programs may include smoking cessation and wellness.

Emergency Services

Emergency services are covered on a twenty-four (24) hour basis without the need for prior authorization for all members experiencing an emergency medical situation.

Molina Healthcare accomplishes this service by providing Utilization Management during business hours and a twenty-four (24) hour Nurse Triage option on the main telephone line for post business hours. In addition, the 911 information is given to all members at the onset of any call to the plan.

For members within our service area; Molina Healthcare contracts with vendors that provide twenty-four (24) hour emergency services for ambulance and hospitals. In the event that our member is outside of the service area, we are prepared to authorize treatment to ensure that the patient is stabilized.

Medical Record Standards

The provider is responsible for maintaining an electronic or paper medical record for each individual member. Records are expected to be current, legible, detailed and organized to allow for effective and confidential patient care by all providers.

Medical records are to be stored in a secure manner that permits easy retrieval. Only authorized personnel may have access to patient medical records.

Providers will develop and implement confidentiality procedures to guard member protected health information, in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy standards and all other applicable federal and state regulations. The provider must ensure their staff receives periodic training regarding the confidentiality of member information.

The provider is responsible for documenting directly provided services. Such services must include, but not necessarily be limited to, family planning services, preventive services, services for the treatment of sexually transmitted diseases, ancillary services, diagnostic services and diagnostic and therapeutic services for which the member was referred to the provider.

At a minimum, each medical record must be legible and maintained in detail with the documentation outlined in Section 8 (Quality Improvement) of this manual.

Medical Necessity Standards

Medically Necessary or Medical Necessity is defined as services that include medical or allied care, goods or services furnished or ordered that are:

- Necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain
- Individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs
- Consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational
- Reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide
- Furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or the provider

The fact that a provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services Medically Necessary, a Medical Necessity or a Covered Service/Benefit.

Specialty Pharmaceuticals

Molina Healthcare contracts with a Specialty Pharmacy vendor to provide an innovative injectable drug delivery program. This service eliminates the cost associated with stocking and billing for office administered specialty injectable drugs for Molina Healthcare members.

Some of the specialty injectable drugs provided by our vendor are:

- Remicade
- Enbrel
- Depot - Lupron
- Interferons

When a Molina Healthcare member needs an injectable medication, the prior authorization request can be submitted to Molina Healthcare by fax at (630) 571-1220. The vendor will coordinate with Molina Healthcare and ship the prescription directly to your office or the member's home. All packages are individually marked for each member, and refrigerated drugs are shipped in insulated packages with frozen gel packs. The service also offers the additional convenience of enclosing needed ancillary supplies (needles, syringes and alcohol swabs) with each prescription at no charge. Please contact your Provider Relations Representative with any further questions about the program.

This Prior Authorization/Pre-Service Guide applies to all Molina Healthcare/Molina Medicare Members.

Referrals to Network Specialists do not require Prior Authorization

Authorization required for services listed below.
Pre-Service Review is required for elective services.

Only covered services will be paid

- **All Non-Par providers/services:** services, including office visits, provided by non-participating providers, facilities and labs, except professional services for ER visit, approved Ambulatory Surgical Center or inpatient stay (except for Women's health/OB services in CA, WA, MI, and IL). ER visits do not require PA
- **All Inpatient Admissions:** Acute hospital, SNF, Rehab, LTACS, Hospice requires notification only
- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services: -** Inpatient, Partial hospitalization, Day Treatment, Intensive Outpatient Programs (IOP), ECT, and > 20 Office Visits/year for adults and children
- **Cardiac Rehabilitation, Pulmonary Rehabilitation, and CORF (Comprehensive Outpatient Rehab Facility services for Medicare only)**
- **Chiropractic Services**
- **Cosmetic, Plastic and Reconstructive Procedures in any setting:** which are not usually covered benefits include but are not limited to tattoo removal, collagen injections, rhinoplasty, otoplasty, scar revision, keloid treatments, and surgical repair of gynecomastia, pectus deformity, mammoplasty, abdominoplasty, venous injections, vein ligation, venous ablation or dermabrasion, botox injections, etc
- **Dental General Anesthesia:** > 7 years old or per state benefit (Not a Medicare covered benefit)
- **Dialysis:** notification only
- **Diapers (not a Medicare covered benefit), Incontinence products**
- **Durable Medical Equipment/Orthotics/Prosthetics:**
  >$500 allowed amount per line item
  All C-PAP and Bi-PAP
  All Orthopedic footwear/orthotics/foot inserts
  All customized orthotics, prosthetics, wheelchairs and braces
  Hearing Aids – including anchored hearing aids
  Medicare Hearing Supplemental benefit: Contact Avesis at 800-327-4462
- **Enteral Formulas & Nutritional Supplements**
- **Experimental/Investigational Procedures**
- **Genetic Counseling and Testing NOT related to pregnancy**
- **Home Healthcare: after 3 skilled nursing visits**
- **Home Infusion**
- **Outpatient Hospice & Palliative Care:** notification only.
- **Imaging:** CT, MRI, MRA, PET, SPECT, Cardiac Nuclear Studies, CT Angiograms, intimal media thickness testing, three dimensional imaging
- **LTSS Services (Waiver eligibility)- e.g., Personal Attendant Services (PAS), Personal Care Services, Day Adult Health Services (DAHS)**
- **Neuropsychological and Psychological Testing and Therapy**
- **Occupational Therapy after initial eval plus 6 visits for outpatient setting and initial eval plus 3 visits for home setting.**
- **Office-Based Surgical Procedures do not require auth except for Podiatry Surgical Procedures** (excluding routine foot care)
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures:** see Prior Auth list on Molina's Web site for specific codes
- **Pain Management Procedures:** including sympathectomies, neurotomies, injections, infusions, blocks, pumps or implants, and acupuncture (Not a Medicare covered benefit)
- **Physical Therapy after initial eval plus 6 visits for outpatient setting and initial eval plus 3 visits for home setting**
- **Pregnancy and Delivery:** notification only
- **Sleep Studies**
- **Speech Therapy**
- **All Specialty Pharmacy including, but not limited to:** Hemophilia drugs, Enbrel, Lupron, Remicade, Avonex, Interferon, Xolair, Humira, Raptiva, Amevive, Synagis, Synvisc, growth hormone, monoclonal antibody, genomic preparations, etc. (except for specific state regulatory requirements)
- **Solid Organ and Bone Marrow Transplant Services:** including the evaluation (except Cornea transplants)
- **Transportation:** non-emergent ground and air ambulance
- **Unlisted CPT and miscellaneous codes >$500 billed charges per line item**
- **Wound Therapy including Wound Vacs and Hyperbaric Wound Therapy**

***STERILIZATION NOTE: Federal guidelines require that at least 30 days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed. The consent form must be submitted with claim. (Medicaid benefit only)**

IMPORTANT INFORMATION FOR MOLINA HEALTHCARE/MOLINA MEDICARE

Information generally required to support authorization decision making includes:

- Current (up to 6 months), adequate patient history related to the requested services.
- Relevant physical examination that addresses the problem.
- Relevant lab or radiology results to support the request (including previous MRI, CT Lab or X-ray report/results)
- Relevant specialty consultation notes.
- Any other information or data specific to the request.

The Urgent / Expedited service request designation should only be used if the treatment is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition will be handled as routine / non-urgent.

- If a request for services is denied, the requesting provider and the member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the provider by telephone or fax. Verbal and fax denials are given within one business day of making the denial decision, or sooner if required by the member's condition.
- Providers can request a copy of the criteria used to review requests for medical services.
- Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician at 888-858-2156

Important Molina Healthcare/Molina Medicare Information	
Prior Authorizations: 8:00 a.m. – 5:00 p.m. Phone: 855-866-5462 Fax: 800-594-7404 **Radiology Authorizations:** Phone: 855-866-5462 Fax: 877-731-7218 **OB/NICU Authorizations:** Phone: 855-866-5462 Fax: 877-731-7218 **Pharmacy Authorizations:** Phone: 855-866-5462 Fax: 866-449-6843 **Behavioral Health Authorizations:** Phone: 855-866-5462 Fax: 800-594-7404 **Transplant Authorizations:** Phone: 855-866-5462 Fax: 877-731-7218 **Member Customer Service Benefits/Eligibility:** Phone: 855-766-5462 TTY/TDD: 711	**Provider Customer Service:** 8:00 a.m. – 5:00 p.m. Phone: 855-866-5462 **24 Hour Nurse Advice Line** English: 1 (888) 275-8750 [TTY: 1-866/735-2929] Spanish: 1 (866) 648-3537 [TTY: 1-866/833-4703] **Vision Care:** Phone: 855-866-5462 **Dental:** Phone: 855-866-5462 **Transportation:** Phone: 877-917-8164

Providers may utilize Molina Healthcare's ePortal at: www.molinahealthcare.com
Available features include:

- **Authorization submission and status**
- **Claims submission and status** (EDI only)
- **Download Frequently used forms**
- **Member Eligibility**
- **Provider Directory**
- **Nurse Advice Line Report**

Molina Healthcare/Molina Medicare Prior Authorization Request Form

Phone Number: 855-866-5462
Fax Number: 800-594-7404

Member Information

Plan: ☐ **Molina Medicaid** ☐ **Molina Medicare** ☐ **Other:**_____

Member's Name:_____ DOB: ____/____

Member's ID#:_____ Member Phone #: ___(____)_____

Service Is: ☐Elective/Routine ☐Expedited/Urgent*

***Definition of Urgent / Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent.**

Referral/Service Type Requested		
Inpatient ☐ Surgical procedures ☐ ER Admits ☐ SNF ☐ Rehab ☐ LTAC	**Outpatient** ☐ Surgical Procedure ☐ Rehab (PT, OT, & ST) ☐ Diagnostic Procedure ☐ Chiropractic ☐ Wound Care ☐ Infusion Therapy	☐ **Home Health** ☐ **DME** ☐ **In Office**

ICD-9 Code & Description:_____

CPT/HCPC Code & Description:_____

Number of visits requested:_____ Date(s) of Service:_____

Please send clinical notes and any supporting documentation

Provider Information

Requesting Provider Name: _____

Facility Providing Service: _____

Contact @ Requesting Provider's: _____

Phone Number: ___(____)_____Fax Number: ___(____)_____

For Molina Use Only:

Molina Healthcare Behavioral Health
Outpatient Treatment Request Form
Phone Number: 855-866-5462
Fax Number: 800-594-7404

Member Information

Plan: ☐ **Molina Medicaid** ☐ **Molina Medicare**

Member Name:_____ DOB: _____

Member ID#:_____ Member Phone #: (_____)_____

Service Is: ☐ Elective/Routine ☐ Expedited/Urgent*

***Definition of Urgent/Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the member's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent.**

Provider Information

Provider/Facility/Clinic Name:_____ Provider NPI/Provider Tax ID#: _____

Contact @ Requesting Provider:_____ Phone #: _____

Address:_____

Clinician Name:_____ Clinician Licensure: ☐ Physician ☐ Psychologist (PhD, PsyD) ☐ Licensed MSW ☐ LLP ☐ LPC ☐ CNP ☐ Other: _____

Provider Phone #: (_____)_____ Fax Number: (_____)_____

Treatment History

Primary Care Physician:_____ Primary Care Physician Phone #: _____

Date of First Visit: _____ Last Clinician/PCP Care Coordination Date: _____

Is treatment being coordinated with the Primary Care Physician? ☐ Yes ☐ No If Yes, Name: _____

Referral/Service Type Requested

Service Is For: ☐ **Mental Health** ☐ **Substance Abuse**

☐ Office Visit/Therapy	☐ Neuropsychological Testing
☐ Medication Management	☐ Psychological Testing
☐ Home Based Services	☐ Other – Describe:
☐ ECT	_____

Current Diagnosis Codes:	Axis I:	Axis II:	Axis III:
	Axis IV:	Axis V Current GAF:	Highest GAF last 12 months:

Procedure Code(s) & Description: _____
Number of days/visits authorized to date: _____ Number of days/visits used to date:_____
Number of days/visits for this request:_____ Date(s) of Service for this request:_____

Please send clinical notes and any supporting documentation

Note: Authorization for services does not guarantee payment. Payment for services are pending eligibility at the time of service and benefit coverage.
***Below For Molina Use Only*:**

Molina Healthcare Behavioral Health
Outpatient Treatment Request Form
Phone Number: 855-866-5462
Fax Number: 800-594-7404

Member Name:_____Member ID#:_____DOB: _____

Clinical Information/Treatment Plan
Please provide the following information with the fax: **Outpatient Sessions Exceeding 20:** • Current treatment plan • Progress notes from last 5 visits (therapy and medication reviews) **Neuropsychological Testing:** • Neurologic condition and/or cognitive impairment (suspected or demonstrated) • History of previous testing • Documentation that medications/substance use have been ruled out as contributing factor • Number of hours requested over how many visits **Psychological Testing:** • Diagnoses • Description of symptoms and impairment • Patient psych and medical history • Family psych and medical history • History of psych testing and results • Test to be administered and # of hours requested, over how many visits • Specific questions the test is intended to answer • What action will be taken/How will treatment plan be affected by results **ECT: Acute/Short-Term:** • Acute symptoms that warrant ECT (specific symptoms of depression, acute mania, psychosis, etc.) • ECT indications (acute symptoms refractory to medication or medication contraindication) • Informed consent from patient/guardian • Personal and family medical history • Personal and family psychiatric history • Medication review • Review of systems • Baseline BP • Evaluation by anesthesia provider • Evaluation by ECT-privileged psychiatrist • Any additional workups completed due to potential medical complications **ECT Continuation/Maintenance:** • Documentation of positive response to acute/short-term ECT • Indications for continuation/maintenance • Informed consent from patient/guardian • Review/Updated history of personal and family medical history • Review/Updated history of personal and family psychiatric history • Medication review • Review of systems • Evaluation by anesthesia provider • Evaluation by ECT-privileged psychiatrist within the last month **Additional information (if not included in above):**

Molina Healthcare Behavioral Health
IP/IOP/PHP Treatment Request Form
Phone Number: 855-866-5462
Fax Number: 800-594-7404

Member Information

Plan: ☐ **Molina Medicaid** ☐ **Molina Medicare**

Member Name: _____ DOB: _____

Member ID#: _____ Member Phone #: (_____) _____

Service Is: ☐ Elective/Routine ☐ Expedited/Urgent*

***Definition of Urgent/Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the member's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent.**

Provider Information

Provider/Facility/Clinic Name: _____ Provider NPI/Provider Tax ID#: _____

Address: _____

Attending Psychiatrist Name: _____ Provider Tax ID#: _____

Provider Phone #: (_____) _____ Fax Number: (_____) _____

Treatment History

Primary Care Physician: _____ Primary Care Physician Phone #: _____

Date of Admission: _____ Last Clinician/PCP Care Coordination Date: _____

Referral/Service Type Requested

Service Is For: ☐ **Mental Health** ☐ **Substance Abuse**

☐ ED Admission: ☐ Voluntary ☐ Involuntary
☐ Direct Admission: ☐ Voluntary ☐ Involuntary

If involuntary: Court Date _____

☐ Partial Hospitalization Program

☐ Intensive Outpatient Program
☐ ECT
☐ Subacute Detoxification
☐ Other – Describe:
_____

Current Diagnosis Codes:	Axis I:	Axis II:	Axis III:
	Axis IV:	Axis V Current GAF:	Highest GAF last 12 months:

Procedure Code(s) & Description: _____

Length of stay requested: _____ Date(s) of Service: _____

Please send clinical notes and any supporting documentation – see page 2.

Note: Authorization for services does not guarantee payment. Payment for services are pending eligibility at the time of service and benefit coverage.
For Molina Use Only:

Molina Healthcare Behavioral Health
IP/IOP/PHP Treatment Request Form
Phone Number: 855-866-5462
Fax Number: 800-594-7404

Member Name:_____Member ID#:_____DOB: _____

Clinical Information/Treatment Plan/Discharge Plan
Please check box below and provide the following information with the fax: ☐ Demographic/Face Sheet ☐ Emergency Center notes ☐ History and Physical ☐ Social work intake form/assessment ☐ Psychiatric evaluation ☐ Relevant Progress notes ☐ Vital signs ☐ Laboratory results ☐ Medication list – current and at discharge ☐ Treatment plan ☐ Discharge sheet/plan ☐ Other information – Describe_____ Additional information (if not included above):

Aftercare Plan/Follow-up Appointments

Provider Type	***Provider Name***	***Telephone Number***	***Date of Appt.***	***Time of Appt.***
Therapist/Program				
Psychiatrist				

Note: First follow-up appointment must be scheduled within seven days of discharge.

Section 8.

QUALITY IMPROVEMENT

Quality Improvement

Molina Healthcare maintains a Quality Improvement (QI) Department to work with members and practitioners/providers in administering the Molina Healthcare Quality Improvement Program (QIP). You can contact the Molina Healthcare QI Department toll free at (888) 858-2156 or fax (630) 571-1220.

The address for mail requests is:

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

This Provider Manual contains excerpts from the Molina Healthcare QIP. For a complete copy Molina Healthcare's QIP you can contact your Provider Services Representative or call the telephone number above to receive a written copy.

Molina Healthcare has established a QIP that complies with regulatory and accreditation guidelines. The QIP provides structure and outlines specific activities designed to improve the care, service and health of our members.

Molina Healthcare does not delegate QI activities to Medical Groups/IPAs. However, Molina Healthcare requires contracted Medical Groups/IPAs to comply with the following core elements and standards of care and to:

- Have a QIP in place
- Comply with and participate in Molina Healthcare QIP including reporting of access and availability and provision of medical records as part of the HEDIS® review process
- Allow access to Molina Healthcare QI personnel for site and medical record review processes

Medical Records

Molina Healthcare 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. Molina Healthcare conducts a medical record review of all PCPs that includes the following components:

- Medical record confidentiality and release of medical records including behavioral health care records;
- Medical record content and documentation standards, including preventive health care;
- Storage maintenance and disposal; and

- Process for archiving medical records and implementing improvement activities.

Practitioners/providers must demonstrate compliance with Molina Healthcare's medical record documentation guidelines. Medical records are assessed based on the following standards:

1. Content:

- Patient name or ID is on all pages
- Current biographical data is maintained in the medical record or database
- All entries contain author identification
- All entries are dated and are indelibly documented
- Medication allergies and adverse reactions are prominently displayed. Absence of allergies is noted in easily recognizable location
- Chronic conditions are listed or noted in easily recognizable location
- Past medical history
- There is appropriate notation concerning use of substances, and for patients, there is evidence of substance abuse query
- The history and physical examination identifies appropriate subjective and objective information pertinent to a patient's presenting complaints and provides a risk assessment of the members health status
- Consistent charting of treatment care plan
- Working diagnoses are consistent with findings
- Treatment plans are consistent with diagnoses
- Encounter notation includes follow up care, call, or return instructions
- Preventive health measures (i.e., immunizations, mammograms, etc.) are noted
- A system is in place to document telephone contacts
- Lab and other studies are ordered as appropriate
- Lab and other studies are initialed by ordering practitioner/provider upon review with Lab results and other studies are filed in chart
- If patient was referred for consult, therapy, or ancillary service, a report or notation of result is noted at subsequent visit, or filed in medical record
- If the practitioner/provider admitted a patient to the hospital in the past twelve (12) months, the discharge summary must be filed in the medical record
- Advanced Directives are documented for those 18 years and older
- A release document for each member authorizing Molina Healthcare to release medical information for facilitation of medical care
- Developmental screenings as conducted through a standardized screening tool
- Documentation of the age-appropriate screening that was provided in accordance with the periodicity schedule
- Documentation of a pregnant member's refusal to consent to testing for HIV infection and any recommended treatment

2. 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

3. Retrieval:

- The medical record is available to practitioner/provider at each encounter
- The medical record is available to Molina Healthcare for purposes of quality improvement
- The medical record is available to the Illinois Department of Healthcare and Family Services and the External Quality Review Organization upon request
- The medical record is available to the member upon their request
- Medical record retention process is consistent with state and federal requirements An established and functional data recovery procedure in the event of data loss

4. Confidentiality:

- Medical Records are protected from unauthorized access
- Access to computerized confidential information is restricted
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information

Additional information on medical records is available from your local Molina Healthcare QI Department toll free at (888) 858-2156. See also Section 16 (HIPAA/Security) for additional information regarding the Health Insurance Portability and Accountability Act (HIPAA).

Access to Care

Molina Healthcare is committed to timely access to care for all members in a safe and healthy environment. Practitioners/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 95% availability for emergency services and 80% or greater for all other services. The PCP or their designee must be available twenty-four (24) hours a day, seven (7) days a week to members.

1. Appointment Access

All practitioners/providers who oversee the member's health care are responsible for providing the following appointments to Molina Healthcare members in the timeframes noted:

Primary Care Practitioner (PCP)	
Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Emergency Care	Immediate
Preventive Care Appointment	Within five (5) weeks of request
Routine Care	Within three (3) weeks of request

Urgent	Within twenty-four (24) hours (Serious problem, not deemed Emergency Care)
After Hours Care	After-Hours Instruction/Standards
After hours emergency instruction	If this is an emergency, please hang up and dial 911
After-Hours Care	Available by phone twenty-four (24) hours/seven (7) days
Prenatal Care	
Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Initial Appointment: First Trimester	Within two (2) weeks of request
Initial Appointment: Second Trimester	Within one (1) week of request
Initial Appointment: Third Trimester	Within three (3) days of request
Behavioral Health	
Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Non-life Threatening Emergency Care	Within ≤ six (6) hours of request
Urgent Care	Within ≤ twenty-four (24) hours of request
Routine Care	Within ≤ ten (10) working days of request

No more than six (6) scheduled appointments shall be made for each PCP per hour. Notwithstanding this limit, it is recognized that physicians supervising other licensed health care providers may routinely account for more than six (6) appointments per hour.

Additional information on appointment access standards is available from your local Molina Healthcare QI Department toll free at (888) 858-2156.

2. Office Wait Time

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

3. After Hours

All practitioners must have back-up (on call) coverage after hours or during the practitioner's absence or unavailability. Molina Healthcare requires practitioners to maintain a twenty-four (24) hour phone service, seven (7) days a week. This access must be through an answering service. The service should instruct members with an emergency to hang-up and call 911 or go immediately to the nearest emergency room. After hours phone calls or pages must be returned within thirty (30) minutes.

4. Appointment Scheduling

Each practitioner must implement an appointment scheduling system. The following are the minimum standards:

- **a.** The practitioner must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments
- **b.** A process for documenting missed appointments must be established. When a member does not keep a scheduled appointment, it is to be noted in the member's record and the practitioner is to assess if a visit is still medically indicated. All efforts to notify the member must be documented in the medical record. If a second appointment is missed, the practitioner is to notify the Molina Healthcare Member Services Department toll free at (855) 766-5462 (TTY/TDD: 711).
- **c.** When the practitioner must cancel a scheduled appointment, the member is given the option of seeing an associate or having the next available appointment time
- **d.** Special needs of members must be accommodated when scheduling appointments. This includes, but is not limited to wheelchair-using members and members requiring language translation
- **e.** A process for member notification of preventive care appointments must be established. This includes, but is not limited to immunizations and mammograms
- **f.** A process must be established for member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test results or the scheduling of procedures which must be performed prior to the next visit.

In applying the standards listed above, participating practitioners/providers have agreed that they will not discriminate against any member on the basis of age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental or sensory handicap, and place of residence, socioeconomic status, or status as a recipient of Medicaid benefits. Additionally, a participating practitioner/provider or contracted medical group/IPA may not limit their practice because of a member's medical (physical or mental) condition or the expectation for the need of frequent or high cost care.

5. Women's Open Access

Molina Healthcare allows members the option to seek obstetrical and gynecological care from an obstetrician or gynecologist or PCP providing obstetrical and gynecological services. Member access to obstetrical and gynecological services is monitored to ensure members have direct access to obstetrical and gynecological services.

Additional information on access to care is available under the Resources tab on the molinahealthcare.com website or from your local Molina Healthcare QI Department toll free at (888) 858-2156.

6. Monitoring Access Standards

Molina Healthcare monitors compliance with the established access standards above. At least annually, Molina Healthcare conducts an access audit of randomly selected contracted practitioner/provider offices to determine if appointment access standards are met. One or all of the following appointment scenarios may be addressed: routine care; acute care; preventive care; and after-hours information. Results of the audit are distributed to the practitioners after its completion. A CAP may be required if standards are not met.

In addition, Molina Healthcare's Member Services Department reviews member inquiry logs and grievances related to delays in access to care. These are reported quarterly to committees. Delays in access that may create a potential quality issue are sent to the QI Department for review.

Additional information on access to care is available under the Resources tab at molinahealthcare.com or is available from your local Molina Healthcare QI Department toll free at (888) 858-2156.

Site and Medical Record-Keeping Practice

Molina Healthcare has a process to ensure that the offices of all practitioners meet its office-site and medical record keeping practices standards. Molina Healthcare assesses the quality, safety and accessibility of office sites where care is delivered. A standard survey form is completed at the time of each visit. This form includes the Office Site Review Guidelines and the Medical Record Keeping Practice Guidelines outlined below and the thresholds for acceptable performance against the criteria. This includes an assessment of:

- Physical accessibility
- Physical appearance
- Adequacy of waiting- and examining-room space
- Availability of appointments
- Adequacy of medical/treatment record keeping

Adequacy of medical record-keeping practices

During the site-visit, Molina Healthcare discusses office documentation practices with the practitioner or practitioner's staff. This discussion includes a review of the forms and methods used to keep the information in a consistent manner and include how the practice ensures confidentiality of records. Molina Healthcare assesses one medical/treatment records for orderliness of record and documentation practices. To ensure member confidentiality, Molina Healthcare reviews a "blinded" medical/treatment record or a "model" record instead of an actual record.

Improvement Plans/ CAPs

If the medical group does not achieve the required compliance with the site review standards and/or the medical record keeping practices review standards, the Site Reviewer will do all of the following:

- Send a letter to the practitioner that identifies the compliance issues
- Send sample forms and other information to assist the practitioner to achieve a passing score on the next review
- Request the practitioner to submit a written CAP to Molina Healthcare within thirty (30) calendar days
- Send notification that another review will be conducted of the office in six (6) months

When compliance is not achieved, the practitioner will be required to submit a written CAP to Molina Healthcare within 30 calendar days of notification by Molina Healthcare. The request for a CAP will be sent certified mail, return receipt requested. This improvement plan should be submitted by the office manager or practitioner and must include the expected time frame for completion of activities.

Additional reviews are conducted at the office at six (6) month intervals until compliance is achieved. At each follow-up visit a full assessment is done to ensure the office meets performance standards. The information and any response made by the practitioner is included in the practitioners permanent credentials file and reported to the Credentialing Committee on the watch status report. If compliance is not attained at follow-up visits, an updated CAP will be required.

Practitioners who do not submit a CAP may be terminated from network participation. Any further action is conducted in accordance with the Molina Healthcare Fair Hearing Plan policy.

Advance Directives (Patient Self-Determination Act)

Advance Directives

Practitioners/providers must inform patients of their right to make health care decisions and execute advance directives. It is important that members are informed about advance directives. During routine medical record review, Molina Healthcare auditors will look for documented evidence of discussion between the practitioner/provider and the member. Molina Healthcare will notify the provider via fax of an individual member's Advance Directives identified through care management, care coordination or case 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 directive form. Advance Directives forms are state specific to meet state regulations.

Each Molina Healthcare practitioner/provider must honor Advance Directives to the fullest extent permitted under law. PCPs must discuss Advance Directives with a member and provide appropriate medical advice if the member desires guidance or assistance. Molina Healthcare's network practitioners and facilities are expected to communicate any objections they may have to a member directive prior to service whenever possible. In no event may any practitioner/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 Healthcare or the state survey and certification agency if the member is dissatisfied with Molina Healthcare's handling of Advance Directives and/or if a practitioner/provider fails to comply with advance directive instructions.

Advance Directives are a written choice for health care. Under Illinois State Law, there are three kinds of directives – Healthcare Power of Attorney, Living will, and Mental Health Treatment Preference Declaration. Written Advance Directives tell the PCP and other medical providers how members choose to receive medical care in the event they are unable to make end-of-life decisions. Each Molina Healthcare provider must honor Advance Directives to the fullest extent permitted under Illinois State Law. Members may select a new PCP if the assigned provider has

an objection to the beneficiary's desired decision. Molina Healthcare will facilitate finding a new PCP or specialist as needed**.**

- **Health Care Power of Attorney** – This Advance Directive names another person to make medical decisions on behalf of members when they cannot make the choices for themselves. It can include plans about the care a member wants or does not want and include information concerning artificial life-support machines and organ donations. This form must be signed, dated and witnessed by a notary public to be valid.
- **Living Will** – This Advance Directive usually states if the member wants to die naturally without life-prolonging care and can also include information about any medical care. A living will only applies if the member has a terminal condition. This directive must be signed, dated and witnessed by two people who know the member well but are not relatives, possible heirs, or health care providers.
- **Mental Health Treatment Preference Declaration—**This Advance Directive allows the member to state if he/she wants to receive electroconvulsive treatment (ECT) or psychotropic medicine when he/she has a mental illness and is unable to make these decisions. It also allows members to say whether they wish to be admitted to a mental health facility for up to seventeen (17) days of treatment. This Advance Directive expires three years from the date of signature. This directive must be signed, dated, and witnessed by two people who know the member well but are not relatives, possible heirs, health care providers or employees of a health care facility in which the member resides.

When There Is No Advance Directive: The member's family and practitioner 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.

Monitoring for Compliance with Standards

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

Quality Improvement Activities and Programs

Molina Healthcare maintains an active QIP. The QIP 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.

1. Clinical Practice Guidelines

Molina Healthcare adopts and disseminates Clinical Practice Guidelines (CPGs) to reduce inter-practitioner/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 appropriate established authority. CPGs are reviewed annually and are updated as new recommendations are published.

Molina Healthcare CPGs include the following:

Asthma	Cholesterol
Chronic Obstructive Pulmonary Disease (COPD)	Coronary Heart Disease
Depression	Diabetes
Hypertension	Substance Abuse Treatment
ADHD	

The adopted CPGs are distributed to the appropriate practitioners, providers, provider groups, staff model facilities, delegates and members by the QI , Provider Services, Health Education and Member Services Departments. The guidelines are disseminated through provider newsletters, Just the Fax electronic bulletins and other media and are available on the Molina Healthcare Website. Individual practitioners or members may request copies from your local Molina Healthcare QI Department toll free at (888) 858-2156.

2. Preventive Health Guidelines

Molina Healthcare provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF) and in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines. Diagnostic preventive procedures include but are not limited to:

- Mammography Screening
- Prostate cancer screening
- Cholesterol screening
- Influenza, pneumococcal and hepatitis vaccines
- Cervical Cancer Screening
- Chlamydia Screening

All guidelines are updated with each release by USPSTF and are approved by the QI Committee. On an annual basis, Preventive Health Guidelines are distributed to practitioners/providers via www.molinahealthcare.com and the provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Healthcare provider newsletter.

3. Cultural and Linguistic Services

Molina Healthcare serves a diverse population of members with specific cultural needs and preferences. Practitioners/providers are responsible to ensure that interpreter services are made available at no cost for members with sensory impairment and/or who are Limited English Proficient (LEP). The following cultural and linguistic services are offered by Molina Healthcare to assist both members and practitioners/providers.

a. 24 Hour Access to Interpreter

Practitioners/providers may request interpreters for members whose primary language is other than English by calling Molina Healthcare's Member Services Department toll free at (855) 766-5462. If Member Services Representatives are unable to provide the interpretation services internally, the member and practitioner/provider are immediately connected to Language Line telephonic interpreter service.

If a patient insists on using a family member as an interpreter after being notified of their right to have a qualified interpreter at no cost, document this in the member's medical record. Molina Healthcare is available to assist you in notifying members of their right to an interpreter. All counseling and treatment done via an interpreter should be noted in the medical record by stating that such counseling and treatment was done via interpreter services. Practitioners/providers should document who provided the interpretation service. That information could be the name of their internal staff or someone from a commercial vendor such as Language Line. Information should include the interpreter's name, operator code number and vendor.

b. Face-to-Face Interpretation

Practitioners/providers may request face-to-face interpretation for scheduled medical visits, if required, due to the complexity of information exchange or when requested by the member. To request face-to-face interpretation services, please contact the QI Department. Additional information on cultural and linguistic services is available at www.molinahealthcare.com and from your local Provider Services Representatives and from the Molina Healthcare Member Services Department.

Measurement of Clinical and Service Quality

Molina Healthcare 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®)
- Provider Satisfaction Survey
- Effectiveness of Quality Improvement Initiatives

Molina Healthcare's most recent results can be obtained from your local Molina Healthcare QI Department toll free at **(888) 858-2156** or fax (630) 571-1220.

Contracted Providers and Facilities must allow Molina Healthcare to use its 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, the following: (1) development of quality improvement activities; (2) public reporting to consumers; (3) preferred status designation in the network; (4) and/or reduced member cost sharing.

1. HEDIS®

Molina Healthcare 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, pre-natal visits, diabetes care, and cardiovascular disease.

HEDIS® results are used in a variety of ways. They are the measurement standard for many of Molina Healthcare's clinical quality improvement 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.

2. CAHPS®

CAHPS® is the tool used by Molina Healthcare to summarize member satisfaction with the health care and service they receive. CAHPS® examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Health Promotion and Education, Coordination of Care and Customer Service. The CAHPS® survey is administered annually in the spring to randomly selected members by a 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 Healthcare's quality improvement activities and are used by external agencies to help ascertain the quality of services being delivered.

3. Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS® both focus on member experience with health care practitioners/providers and health plans, Molina Healthcare conducts a Provider Satisfaction Survey annually. The results from this survey are very important to Molina Healthcare, as this is one of the primary methods we use to identify improvement areas pertaining to the Molina Healthcare provider network. The survey results have helped establish improvement activities relating to Molina Healthcare's specialty network, inter-provider communications, and pharmacy authorizations. This survey is fielded to a random sample of practitioners/providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

4. Effectiveness of Quality Improvement Initiatives

Molina Healthcare 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.

Health, Safety and Welfare

As a provider and participant in Molina's quality improvement processes, you have a right to have access to information about Molina's quality improvement programs, including program goals, processes, and outcomes that relate to member care and services. This includes information on Potential Quality of Care events (PQOC) and member safety issues.

As an integral component of health care delivery by all providers, Molina supports identification and implementation of a complete range of member safety activities. These activities include medical record legibility and documentation standards, communication and coordination of care across the health care network, medication allergy awareness/documentation, drug interactions, utilization of evidence-based clinical guidelines to reduce practice variations, tracking and trending adverse events/quality of care issues/quality of service issues including Critical Incidents, and grievances related to

Quality of Care Issues

Quality of care (QOC) issues may be identified by providers, members, regulatory agencies or any department within Molina, including but not limited to, Member Services, Grievance, Regulatory Affairs, Provider Relations, Risk Management, Health Care Services (Utilization Management (UM), Case Management (CM), Disease Management (DM), Quality Improvement (QI) or the Medical Director(s).

Quality of Care category types include but are not limited to:

- Procedural events
- Medication issues
- Delay/Omission of care
- Death or serious disability resulting from services rendered
- Post-operative complications; and
- Patient safety concerns
- Allegations of abuse, neglect and exploitation
- Critical incidents

QI staff will:

- Investigate the QOC issue;
- Review the case against peer established criteria; and
- Document the nurse reviewer's analysis

Abuse, Neglect and Exploitation

Adult Protective Services (APS) agencies are designed to protect elders and vulnerable adults from abuse, neglect or exploitation. Agencies such as the Department on Aging (DOA), the Department of Rehabilitation Services (DRS), and Health and Family Services (HFS) have defined processes for ensuring elderly victims of abuse, neglect or

exploitation in need of home and community-based services are identified, referred to the appropriate regulatory agency, and reports are tracked and trended. Abuse includes indications of physical, sexual, verbal and psychological abuse. Neglect includes unsafe living arrangements and indications that a member's basic needs are not being met. Basic needs include the need for medical care as well as physical and emotional needs. Exploitation for the elderly population is primarily related to financial loss. As a provider and mandated reporter, you need to be aware of and look for signs of Abuse, Neglect and Exploitation during contacts with your patients and Molina members. You should look for signs of caregiver stress that may be a concomitant indicator of abuse or neglect. You should assess for use or mention of restraints by caregivers as this is not an acceptable practice.

Reports of abuse, neglect and exploitation should be made to the DOA administered **Elder Abuse Hotline 1-866-800-1409 (VOICE), 1-888-206-1327 (TTY)** for victims aged sixty (60) and older who reside in the community and are receiving home and community-based services. To report abuse/neglect for the elderly in hospitals or nursing homes call the Illinois Department of Public Health (IDPH) ombudsman hotline at **1-800-252-4343.**

Reports of abuse, neglect and exploitation of members residing in Supportive Living Facilities (SLF) should be made to the Department of Healthcare and Family Services' (**HFS**) **SLF Complaint Hotline at 1-800-226-0768**.

Reports of abuse, neglect and exploitation should be made to the Department of Human Services (DHS) Office of the Inspector General **(OIG) 24-hour hotline 1-800-368-1463 voice/tty.**

Molina may immediately terminate or it may suspend, pending investigation, the participation status of a provider who, in the opinion of Molina's Chief Medical Officer and/or Peer Review Committee, is engaged in behavior or who is practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of members.

Molina has a Peer Review process in the event that there is a need to alter the conditions of participation of a provider based on issues of quality of care, member safety and welfare, conduct or service. If such process is implemented, it may result in Molina reporting to regulatory agencies. Please refer to the **Credentialing, Appeal Rights and Fair Hearing** sections of this manual for further information.

Section 9.

CLAIMS

As a contracted provider, it is important to understand how the claims process works to avoid delays in processing your claims. The following items are covered in this section for your reference:

- Claim Submission
- Corrected Claim
- Claims Disputes/Adjustments
- Overpayments/Refund Requests
- Coordination of Benefits (COB)
- Third Party Liability (TPL)
- Billing the Member

Claim Submission

Claims may be submitted to Molina Healthcare with appropriate documentation by mail or filed electronically (EDI) for CMS-1500 and UB-04 claims. For members assigned to a delegated medical group/IPA that processes its own claims, please verify the "Remit To" address on the member's Molina Healthcare ID card (Refer to Section 2). Providers billing Molina Healthcare directly should send claims to:

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

Providers billing Molina Healthcare electronically should use current HIPAA compliant ANSI X12N format (e.g., 837I for institutional claims, 837P for professional claims, and 837D for dental claims) and use electronic payor ID number: 20934**.**

Providers must use good faith effort to bill Molina Healthcare for services with the most current coding (ICD-9, CPT, HCPCS etc.) available. The following information must be included on every claim:

- Institutional Providers:
    - The completed UB 04 data set or its successor format adopted by the National Uniform Billing Committee (NUBC), submitted on the designated paper or electronic format as adopted by the NUBC. Entries stated as mandatory by NUBC and required by federal statue and regulations and any state designated data requirements included in statues or regulation.

- Physicians and Other Professional Providers:
    - The Centers for Medicare and Medicaid Services (CMS) Form 1500 or its successor adopted by the National Uniform Claim Committee (NUCC) submitted on the designated paper or electronic format. Current Procedural Terminology (CPT) codes and modifiers and International Classification of Diseases (ICD-9)

codes. Entries states as mandatory by NUCC and required by federal statute and regulation and any state designated data requirements included in statutes or regulations.

National Provider Identifier (NPI)

Providers must report any changes in their NPI or subparts to Molina Healthcare within thirty (30) calendar days of the change.

Documents that do not meet the criteria described above may result in the claim being denied or returned to the provider. Claims must be submitted on the proper claim form, either a CMS-1500 or UB-04. Molina Healthcare will only process legible claims received on the proper claim form containing the essential data requirements. Incomplete, inaccurate, or untimely re-submissions may result in denial of the claim.

Electronic Claim Submissions

Molina Healthcare also accepts electronic claim submissions for both claims and encounters using the CMS-1500 and UB-04 claim types. Please use Molina Healthcare's Electronic Payor ID number – 20934. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure claims are received for processing in a timely manner.

When your claims are filed electronically:

- You should receive an acknowledgement from your current clearinghouse
- You should receive an acknowledgement from Emdeon within two (2) business days of your transmission
- You should contact your local clearinghouse representative if you experience any problems with your transmission
- For any direct submissions to Molina Healthcare you should receive an acknowledgement of your transmission

Timely Claim Filing

Provider shall promptly submit to Molina Healthcare claims for covered services rendered to members. All claims shall be submitted in a form acceptable to and approved by Molina Healthcare , and shall include any and all medical records pertaining to the claim if requested by Molina Healthcare or otherwise required by Molina Healthcare's policies and procedures. Claims must be submitted by provider to Molina Healthcare within one hundred eighty (180) calendar days after the following have occurred: discharge for inpatient services or the date of service for outpatient services; and provider has been furnished with the correct name and address of the member's health maintenance organization. If Molina Healthcare is not the primary payer under coordination of benefits, provider must submit claims to Molina Healthcare within ninety (90) calendar days after final determination by the primary payer. Except as otherwise provided by law or provided by government sponsored program requirements, any claims that are not submitted to Molina Healthcare within these timelines shall not be eligible for payment, and provider hereby waives any right to payment therefore.

Fraud and Abuse

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

Timely Claim Processing

Claims payment will be made to contracted providers in accordance with the timeliness provisions set forth in the provider's contract. Unless the provider and Molina Healthcare or contracted medical group/IPA have agreed in writing to an alternate payment schedule, Molina Healthcare will pay the provider of service within thirty (30) calendar days after receipt of clean claims.

The receipt date of a claim is the date Molina Healthcare receives either written or electronic notice of the claim.

Claim Editing Process

Molina Healthcare has a claims pre-payment auditing process that identifies frequent billing errors such as:

- Bundling and unbundling coding errors
- Duplicate claims
- Services included in global care
- Incorrect coding of services rendered

Coding edits are generally based on state fee for service Medicaid edits, AMA, Current Procedural Terminology (CPT), HRSA and National Correct Code Initiative (NCCI) guidelines. If you disagree with an edit please refer to the Claim Disputes/Adjustments section below.

Coordination of Benefits and Third Party Liability

COB

Medicaid is the payor of last resort. Private and governmental carriers must be billed prior to billing Molina Healthcare or medical groups/IPAs. Provider shall make reasonable inquiry of members to learn whether member has health insurance, benefits or Covered Services other than from Molina Healthcare or is entitled to payment by a third party under any other insurance or plan of any type, and provider shall immediately notify Molina Healthcare of said entitlement. In the event that coordination of benefits occurs, provider shall be compensated in an amount equal to the allowable Clean Claim less the amount paid by other health plans, insurance carriers and payers, not to Molina Healthcare's contracted allowable rate. The provider must include a copy of the other insurance's EOB with the claim.

Third Party Liability

Molina Healthcare will pay claims for covered services when probable Third Party Liability (TPL) has not been established or third party benefits are not available to pay a claim. Molina Healthcare will attempt to recover any third-party resources available to members and shall maintain records pertaining to TPL collections on behalf of members for audit and review.

Corrected Claims

Corrected claims are considered new claims. Corrected claims may be submitted electronically with the appropriate field on the 837 I or 837 P completed. Paper corrected claims need to be marked as corrected and should be submitted to the following address:

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

Claims Disputes/Adjustments

Providers seeking a redetermination of a claim previously adjudicated must request such action within ninety (90) days of Molina Healthcare's original remittance advice date. Additionally, the item(s) being resubmitted should be clearly marked as a redetermination and must include the following:

- The item(s) being resubmitted should be clearly marked as a Claim Dispute/ Adjustment.
- Payment adjustment requests must be fully explained.
- The previous claim and remittance advice, any other documentation to support the adjustment and a copy of the referral/authorization form (if applicable) must accompany the adjustment request.
- The claim number clearly marked on all supporting documents

These requests shall be classified as a Claims Disputes/Adjustment and be sent to the following address:

Molina Healthcare of Illinois
Attention: Claims Disputes / Adjustments
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523

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 Healthcare of Illinois' decision in writing within sixty (60) calendar days of receipt of the Claims Dispute/Adjustment request. Providers may **not** "bill" the member when a denial for covered services is upheld per review. A redetermination request, which differs from "Provider Dispute/Adjustment" request, must be submitted within one**-**hundred**-**twenty (120) days of the original RA from Molina Healthcare in order to be considered. Providers may request a claim redetermination when the claim was incorrectly denied as a duplicate or due to claims examiner or data-entry error.

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of coverage decisions or payment levels, Molina Healthcare determines that it has made an overpayment to a provider for services rendered to a member, it will make a claim for such overpayment. Molina Healthcare will not reduce payment to that

provider for other services unless the provider agrees to the reduction or fails to respond to Molina Healthcare's claim as required in this subsection.

A provider shall pay a claim for an overpayment made by a Molina Healthcare which the provider does not contest or deny within the specified number of days on the refund request letter mailed 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 the organization, or the date that the provider receives a payment from the organization that reduces or deducts the overpayment.

Billing the Member

Molina Healthcare contracted providers may not bill the member for any covered benefit. The contract between the provider and Molina Healthcare places the responsibility for verifying eligibility and obtaining approval for those services that require prior authorization on the provider.

Encounter Data

Each capitated provider/organization delegated for claims payment is required to submit encounter data to Molina Healthcare for all adjudicated claims. The data is used for many purposes, such as reporting to HFS, rate setting and risk adjustment, hospital rate setting, the Quality Improvement program and HEDIS reporting.

Encounter data must be submitted once per month, and must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I – Institutional, 837P – Professional, and 837D -- Dental. Data must be submitted with claims level detail for all non-institutional services provided. For institutional services, only those services covered by Molina Healthcare should be reported.

Molina Healthcare shall have a comprehensive automated and integrated encounter data system capable of meeting these requirements.

Molina Healthcare will create Molina Healthcare's 837P, 837I, and 837D Companion Guides with the specific submission requirements available to providers.

Section 10.

HOSPITALS

This section includes policies and procedures specific to contracted hospitals. We have included information pertaining to emergency care and admissions.

Emergency Care

A medical screening exam performed by licensed medical personnel in the emergency department and subsequent emergency care services rendered to the member do not require prior authorization from Molina Healthcare.

Members accessing the emergency department inappropriately will be contacted by Molina Healthcare Case Managers whenever possible to determine the reason for using emergency

services. Case Managers will also contact the PCP to ensure that members are not accessing the emergency department because of an inability to be seen by the PCP.

Admissions

Hospitals are required to notify Molina Healthcare within twenty four (24) hours or the first working day of any inpatient admissions, including deliveries, in order for hospital services to be covered. Prior authorization is required for inpatient or outpatient surgeries. Retroactive authorization requests for services rendered will normally not be approved.

Claims Submission

Claims must be submitted in accordance with the guidelines and processes set forth in the "Claims" section of this manual.

Section 11.

FRAUD AND ABUSE

Introduction

Molina Healthcare maintains a comprehensive Fraud, Waste and Abuse program. The program is held accountable for the special investigative process in accordance with federal and state statutes and regulations. The Program is administered by the Compliance department and is responsible for the prevention, detection, and investigation and reporting of potential health care fraud and abuse cases to the appropriate law enforcement and regulatory entities. The Program also addresses fraud prevention and the education of appropriate employees, vendors, providers and associates doing business with Molina Healthcare.

Mission Statement

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

Compliance Department Contact Information

Telephone: (888) 858-2156

Fax: (630) 571-1220

Mail:

Compliance Official

Molina Healthcare

1520 Kensington Rd., Suite 212

Oak Brook, IL 60523

Regulatory Requirements

Federal False Claims Act

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.

Deficit Reduction Act

On February 8, 2006, the Deficit Reduction Act ("DRA") was signed into law, which became effective on January 1, 2007. The DRA aims to cut fraud, waste and abuse from the Medicare and Medicaid programs over the next five years.

Health care entities like Molina Healthcare who receive or pay out at least $5 million dollar in Medicaid funds per year must comply with DRA. As a contractor doing business with Molina Healthcare, providers and their staff have the same obligation to report any actual or suspected violation of Medicare/Medicaid funds either by fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

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

The Federal False Claims Act and the Medicaid False Claims Act 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 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 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 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 to ensure compliance with the law.

Definitions

Fraud:

Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to oneself or some other person. This includes any act that constitutes fraud under applicable Federal or State law.

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. For example,: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of poor or inefficient billing methods (e.g. coding) that causes unnecessary costs to the Medicaid/Medicare programs.

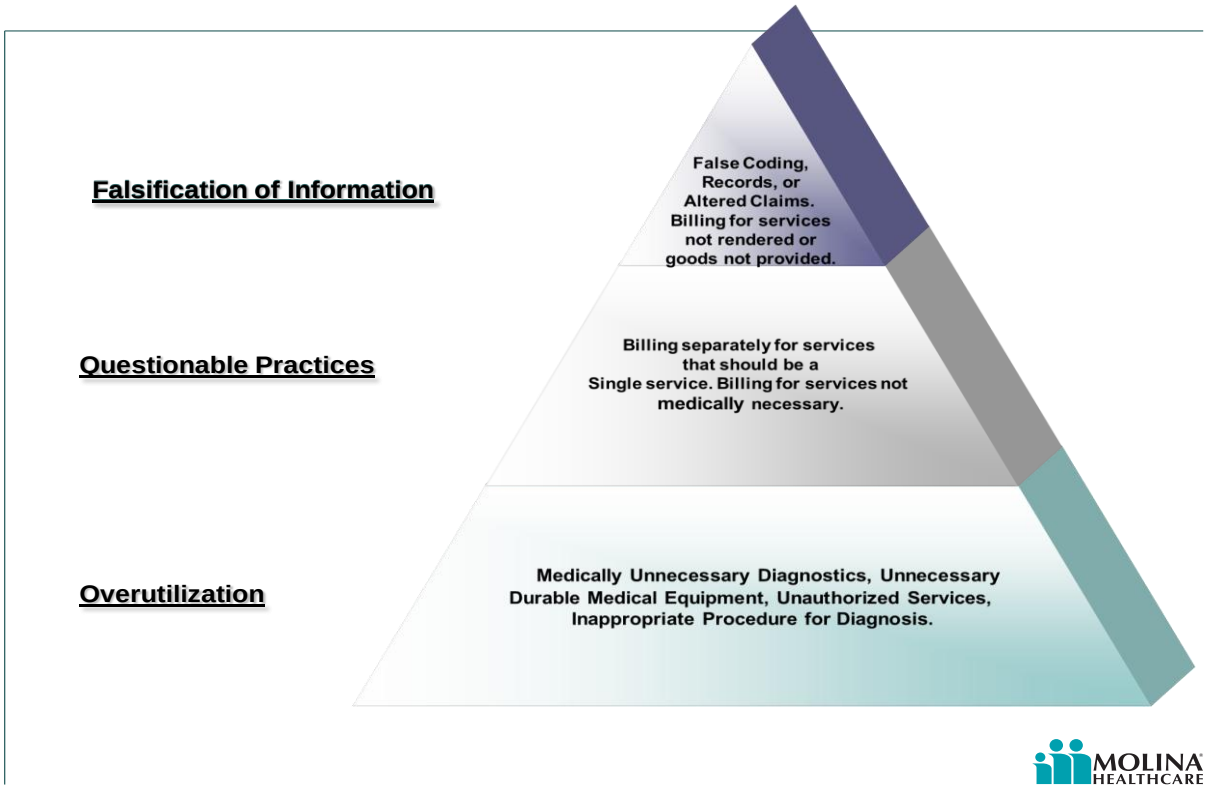
Abuse:

Practices that are inconsistent with sound fiscal, business, or medical practices that result in an unnecessary cost to the government program or in reimbursement for services that are not medically necessary, or fail to meet professionally recognized standards for health care.

Examples of Fraud, Waste and Abuse by a Provider

- Billing for services, procedures and/or supplies that have not been actually been rendered.
- Providing services to patients that are not medically necessary.
- Balancing Billing a Medicaid member for Medicaid covered services.
- Intentional misrepresentation of manipulating the benefits payable for services, procedures and or supplies, dates on which services and/or treatments were rendered, medical record of service, condition treated or diagnosed, charges or reimbursement, identity of provider/practitioner or the recipient of services, "unbundling" of procedures, non-covered treatments to receive payment , "up-coding", and billing for services not provided.
- Concealing patients misuse of Molina Healthcare identification card.
- Failure to report a patient's forgery/alteration of a prescription.

- Knowingly and willfully solicits or receives payment of kickbacks or bribes in exchange for the referral of Medicare or Medicaid patients.
- A physician knowingly and willfully referring Medicare or Medicaid patients to health care facilities in which or with which the physician has a financial relationship. (The Stark Law)
- Balance Billing – asking the patient to pay the difference between the discounted fees, negotiated fees, and the provider's usual and customary fees.



Review of Provider

The Credentialing Department is responsible for monitoring practitioners through the various government reports, including:

- Medicaid Sanction Report
- List of parties excluded from Federal Procurement and Non-procurement Programs
- Medicaid suspended and ineligible provider list
- Monthly review of each state Medical Board "Hot Sheet"
- Review of license reports from the appropriate specialty board

If a match is found, the Credentialing Services staff will request copies of relevant information from the appropriate government entity. Upon receiving this information the documents are

presented to the Credentials Committee for review and potential action. The Credential Services staff will also present the list of physicians found on the Medicaid sanctions report to the Compliance Committee for review and potential oversight of action.

Provider Profiling

Molina Healthcare performs claims audits to detect potential external health care fraud. These audits of provider billings are based on objective and documented criteria. Molina Healthcare uses a fraud and abuse detection software application designed to score and profile providers and members billing behavior and patterns on a daily basis. The software utilizes a fraud finder engine to identify various billing behaviors, billing patterns, known schemes, as well as unknown patterns by taking into consideration a provider or member's prior billing history. The software statistically identifies what is expected based on prior history and specialty norms, including recognition of pattern changes from those identified in profiled historical paid claims data and ongoing daily claims batches. If a score reaches a certain parameter or threshold, the provider or member is placed on a list for further review.

A provider profile report is then created and sent to the Compliance Department. Molina Healthcare will inform the provider of the billing irregularities and requests an explanation of the billing practices. The Compliance department may conduct further investigation and take action as needed.

Provider/Practitioner Education

When the Compliance Official identifies through an audit, provider profile or other means a situation with a provider (e.g. coding, billing) that is either inappropriate or deficient, the Compliance Officer may determine that a provider/practitioner education visit is appropriate.

The Compliance Official will contact the provider/practitioner's Provider Services Representative regarding the education issue. The Provider Services Representative will be informed that an on-site meeting at the provider's office is required in order to education the provider on certain issues identified as inappropriate or deficient.

Review of Provider Claims and Claims System

Molina Healthcare Claim Examiners are trained to recognize unusual billing practices and to detect fraud and abuse. If the Claim Examiner suspects fraudulent billing practices, the billing practice is documented and reported to the Compliance Official of the state health plan in question.

The claims payment system utilizes system edits and flags to validate those 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 Healthcare performs auditing to ensure the accuracy of data inputted 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.

Reporting Fraud, Waste and Abuse

If you suspect cases of fraud, waste or abuse, you must report it to the **Molina Healthcare's Compliance Official**. You have the right to have your concerns reported anonymously without fear of retaliation. 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

You may also report suspected fraud and abuse related directly to the state at:

Illinois State Police
Medicaid Fraud Control Unit
8151 W. 183rd Street, Suite F
Tinley Park, Illinois 60477

Toll Free Phone: **(888) 557-9503**

Illinois Attorney General

Online at: http://www.state.il.us/agency/oig/reportfraud.asp

Section 12.

CREDENTIALING AND RECREDENTIALING

The purpose of the Credentialing Program is to strive to assure that the Molina Healthcare network consists of quality practitioners/providers who meet clearly defined criteria and standards. It is the objective of Molina Healthcare to provide superior health care to the community.

The decision to accept or deny a credentialing applicant is based upon primary source verification, recommendation of peer practitioners/providers and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under state and federal law.

The Credentialing Program has been developed in accordance with state and federal requirements and accreditation guidelines. In accordance with those standards, Molina

Healthcare members will not be referred and/or assigned to you until the credentialing process has been completed.

Criteria for Participation in the Molina Healthcare Network

Molina Healthcare has established criteria and the sources used to verify these criteria for the evaluation and selection of practitioners for participation in the Molina Healthcare network. This policy defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the Molina Healthcare network.

Molina Healthcare reserves the right to exercise discretion in applying any criteria and to exclude practitioners who do not meet the criteria. To remain eligible for participation practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Molina Healthcare.

Practitioners should adhere strictly to the ethics of the profession, have demonstrated a temperament and ability to work cooperatively with others free of evidence of a disruptive personality, and be willing to participate in the provision of cost effective and quality services in the managed care environment, including but not limited to the discharge of Molina Healthcare responsibilities.

Practitioners must meet the following criteria to be eligible to participate in the Molina Healthcare network. If the practitioner fails to provide proof of meeting these criteria, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the Molina Healthcare network. Practitioners who fail to provide proof of meeting these criteria do not have the right to submit an appeal.

1. Practitioner must practice, or plan to practice within ninety (90) calendar days, within the area served by Molina Healthcare.
2. All providers, including ancillary providers, (i.e. vision, pharmacy, etc.), will apply for enrollment in the Medicaid program. Providers are required to have an NPI or an Administrative Provider Identification Number (APIN).
3. Practitioner must have a current, valid license to practice in their specialty in every state in which they will provide care for Molina Healthcare members.
4. Practitioner must have current professional malpractice liability coverage with limits that meet Molina Healthcare criteria specifically outlined in Addendum B of this policy.
5. If applicable to the specialty, practitioner must have a current and unrestricted federal Drug Enforcement Agency (DEA) certificate and Controlled Substance Certification or Registration.
6. Dentists, Oral Surgeons, Physicians (MDs, DOs) and Podiatrists will only be credentialed in an area of practice in which they have adequate training as outlined below. Therefore, they must confine their practice to their credentialed area of practice

when providing service to Molina Healthcare members. Adequate training must be demonstrated by one of the following:

7. Current Board Certification by a board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the American Dental Association in the credentialed area of practice, the American Board of Podiatric Surgery, the American Board of Podiatric Orthopedic and Primary Medicine (ABPOPM), or the American Board of Oral and Maxillofacial Surgery
8. Successful completion of a residency or fellowship program accredited by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA) in the United states or by the College of Family Physicians in Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA).
9. Practitioners who are not Board Certified as described in section 5a above and have not completed an accredited Residency program are only eligible to be considered for participation as a General Practitioner in the Molina Healthcare network. To be eligible as a General Practitioner, the practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five years without any gaps in work history.
10. At the time of initial application, the practitioner must not have any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body.[1]
11. Practitioner must not be currently excluded, expelled or suspended from any state or federally funded program including but not limited to the Medicare or Medicaid programs.
12. Practitioner must not have been convicted of a felony or pled guilty to a felony for a healthcare related crime including but not limited to healthcare fraud, patient abuse and the unlawful manufacture distribution or dispensing of a controlled substance.
13. Practitioners not able to practice independently according to state law (e.g. NP's, Midwives, PA-C's) must have a practice plan with a supervising physician approved by the state licensing agency. The supervising physician must be contracted and credentialed with Molina Healthcare.
14. Physicians, Primary Care Practitioners, Midwives, Oral Surgeons and Podiatrists must have admitting privileges in their specialty or have a plan for hospital admission by using a Hospital Inpatient Team or having an arrangement with a credentialed Molina Healthcare participating practitioner that has the ability to admit Molina Healthcare patients to a hospital. Practitioners practicing exclusively on a consultative basis are not required to have admitting hospital privileges.
15. Licensed midwives who perform deliveries outside of an acute care hospital must have a formal arrangement in place with an OB/Gyn contracted and credentialed with Molina

[1] If a practitioner's application is denied solely because a practitioner has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the practitioner may reapply as soon as practitioner is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action, or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one year from the date of original denial.

Healthcare. This arrangement must include twenty-four (24) hour coverage and inpatient care for Molina Healthcare members in the event of emergent situations. Family practitioners providing obstetric care may provide the back-up in rural areas that do not have an OB/Gyn. This back-up physician must be located within 30 minutes from the midwives practice.

16. If applicable to the specialty, practitioner must have a plan for shared call coverage that includes twenty-four (24) hours a day, seven (7) days per week and 365 days per year. The covering practitioner(s) must be qualified to assess over the phone if a patient should immediately seek medical attention or if the patient can wait to be seen on the next business day.
17. Molina Healthcare may determine, in its sole discretion, that a practitioner is not eligible to apply for network participation if the practitioner is an employee of a practitioner or an employee of a company owned in whole or in part by a practitioner, who has been denied or terminated from network participation by Molina Healthcare, who is currently in the Fair Hearing Process, or who is under investigation by Molina Healthcare. Molina Healthcare also may determine, in its sole discretion that a practitioner cannot continue network participation if the practitioner is an employee of a practitioner or an employee of a company owned in whole or in part by a practitioner, who has been denied or terminated from network participation by Molina Healthcare. For purposes of this criteria, a company is “owned” by a practitioner when the practitioner has a majority financial interest in the company, through shares or other means.
18. Practitioner’s denied or terminated by the Credentialing Committee are not eligible to reapply until one year after the date of denial or termination by the Credentialing Committee. At the time of reapplication, practitioner must meet all criteria for participation as outlined above.

Burden of Proof

The practitioner shall have the burden of producing adequate information to prove he/she meets all criteria for initial participation and continued participation in the Molina Healthcare network. This includes but is not limited to proper evaluation of their experience, background, training, demonstrated ability and ability to perform as a practitioner without limitation, including physical and mental health status as allowed by law, and the burden of resolving any doubts about these or any other qualifications to participate in the Molina Healthcare network. If the practitioner fails to provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the Molina Healthcare network. Practitioners who fail to provide this burden of proof do not have the right to submit an appeal.

Practitioner Termination and Reinstatement

If a practitioner’s contract is terminated and later it is determined to reinstate the practitioner, the practitioner must be initially credentialed prior to reinstatement if there is a break in service more than 30 calendar days. The credentialing factors that are no longer within the credentialing time limits and those that will not be effective at the time of the Credentialing Committee's review must be re-verified. The Credentialing Committee or medical director, as appropriate, must review all credentials and make a final determination prior to the practitioner's reentry into the network.

If a practitioner is given administrative termination for reasons beyond Molina Healthcare’s control (e.g., the practitioner failed to provide complete credentialing information), and is then reinstated within thirty (30) calendar days, Molina Healthcare may recredential the practitioner

as long as there is clear documentation that the practitioner was terminated for reasons beyond Molina Healthcare's control and was recredentialed and reinstated within thirty (30) calendar days of termination. Molina Healthcare must initially credential the practitioner if reinstatement is more than thirty (30) calendar days after termination.

If Molina Healthcare is unable to recredential a practitioner within thirty-six (36) months because the practitioner is on active military assignment, maternity leave or sabbatical; but the contract between Molina Healthcare and the practitioner remains in place, Molina Healthcare will recredential the practitioner upon his or her return. Molina Healthcare will document the reason for the delay in the practitioner's file. At a minimum, Molina Healthcare will verify that a practitioner who returns has a valid license to practice before he or she can resume seeing patients. Within 60 calendar days of notice when the practitioner resumes practice, Molina Healthcare will complete the recredentialing cycle. If either party terminates the contract and there is a break in service of more than thirty (30) calendar days, Molina Healthcare will initially credential the practitioner before the practitioner rejoins the network.

Practitioners Terminating with a Delegate and Contracting with Molina Healthcare Directly

Practitioners credentialed by a delegate who terminate their contract with the delegate and want to contract with Molina Healthcare directly must be credentialed by Molina Healthcare within six-months of the practitioner's termination with the delegate. If the practitioner has a break in service more than thirty (30) calendar days, the practitioner must be initially credentialed prior to reinstatement.

Credentialing Application

At the time of initial credentialing and recredentialing, the practitioner must complete a credentialing application designed to provide Molina Healthcare with information necessary to perform a comprehensive review of the practitioner's credentials. The application must be completed in its entirety. The practitioner must attest that their application is complete and correct within 180 calendar days of the credentialing decision. The application must be completed in typewritten text, in pen or electronically through applications such as the Counsel for Affordable Quality Healthcare (CAQH) Universal Credentialing Data Source. Pencils or erasable ink will not be an acceptable writing instrument for completing credentialing applications. Molina Healthcare may use another organization's application as long as it meets all the factors outlined in this policy. Molina Healthcare will accept faxed, digital, electronic, scanned or photocopied signatures. A signature stamp is not acceptable on the attestation. The attestation must include:

- Reason for any inability to perform the essential functions of the position, with or without accommodation
- Lack of present illegal drug use
- History of loss of license and felony convictions
- History of loss or limitation of privileges or disciplinary action
- Current malpractice insurance coverage and
- The correctness and completeness of the application

Inability to perform essential functions and illegal drug use

An inquiry regarding illegal drug use and inability to perform essential functions may vary. Practitioners may use language other than "drug" to attest they are not presently using illegal substances. Molina Healthcare may accept more general or extensive language to query practitioners about impairments; language does not have to refer exclusively to the present, or only to illegal substances.

History of actions against applicant

An application must contain the following information.

- History of loss of license
- History of felony convictions
- History of all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which a practitioner has had privileges

Current malpractice coverage

The application form must include specific questions regarding the dates and amount of a practitioner's current malpractice insurance. Molina Healthcare may obtain a copy of the insurance face sheet from the malpractice carrier in lieu of collecting the information in the application.

For practitioners with federal tort coverage, the application need not contain the current amount of malpractice insurance coverage. Practitioner files that include a copy of the federal tort letter or an attestation from the practitioner of federal tort coverage are acceptable.

Correctness and completeness of the application

Practitioners must attest that their application is complete and correct when they apply for credentialing and recredentialing. If a copy of an application from an entity external to Molina Healthcare is used, it must include an attestation to the correctness and completeness of the application. Molina Healthcare does not consider the associated attestation elements as present if the practitioner did not attest to the application within the required time frame of 180 days. If state regulations require Molina Healthcare to use a credentialing application that does not contain an attestation, Molina Healthcare must attach an addendum to the application for attestation.

Meeting Application time limits

If the practitioner attestation exceeds 180 days before the credentialing decision, the practitioner must attest that the information on the application remains correct and complete, but does not need to complete another application. It is preferred to send a copy of the completed application with the new attestation form when requesting the practitioner to update the attestation.

The Process for Making Credentialing Decisions

All practitioners requesting initial participation with Molina Healthcare must complete a credentialing application. To be eligible to submit an application, practitioners must meet all the criteria outlined above in the section titled “Criteria for Participation in the Molina Healthcare Network”. Practitioners may not provide care to Molina Healthcare members until the final decision is rendered by the Credentialing Committee or the Molina Healthcare Medical Director.

Molina Healthcare recredentials its practitioners at least every thirty-six (36) months. Approximately six months prior to the recredentialing due date, a request will be sent to the practitioner requesting completion of a recredentialing application.

During the initial and recredentialing application process, the practitioner must:

- Submit a completed application within the requested timeframe
- Attest to the application within the last 180 calendar days
- Provide Molina Healthcare adequate information to prove he/she meets all criteria for initial participation or continued participation in the Molina Healthcare network.

Once the application is received, Molina Healthcare will complete all the verifications as outlined in the attached Practitioner Criteria and Primary Source Verification Table. In order for the application to be deemed complete, the practitioner must produce adequate information to prove he/she meets all criteria for initial participation or continued participation in the Molina Healthcare network. All fields within the application must be completed, all required attachments must be included, detailed explanations must be provided to all affirmative answers on the attestation questions and any additional information requested by Molina Healthcare must be provided.

If the practitioner does not provide the information necessary to complete the application process in the time period requested, the application will be deemed incomplete and Molina Healthcare will discontinue processing of the application. This will result in an administrative denial or termination from the Molina Healthcare network. Practitioners who fail to provide proof of meeting criteria or fail to provide a complete credentialing application do not have the right to submit an appeal.

At the completion of the application and primary source verification process, each credentialing file is quality reviewed to ensure completeness. During this quality review process each credentialing file is assigned a level based on established guidelines. Credentialing files assigned a level 1 are considered clean credentialing files and the Medical Director(s) responsible for credentialing has the authority to review and approve them. Credentialing files assigned a level 2 are reviewed by the Molina Healthcare Credentialing Committee.

At each Credentialing Committee meeting, practitioner credentials files assigned a Level 2 are reviewed by the Credentialing Committee. All of the issues are presented to all the Credentialing Committee members and then open discussion of the issues commences. After the discussion, the Credentialing Committee votes for a final decision. The Credentialing Committee can approve, deny, terminate, approve on watch status, place on corrective action or defer their decision pending additional information.

Process for Delegating Credentialing and Recredentialing

Molina Healthcare will delegate credentialing and recredentialing activities to Independent Practice Associations (IPA) and Provider Groups that meet Molina Healthcare's requirements for delegation. Molina Healthcare's Delegation Oversight Committee (DOC) must approve all delegation and subdelegation arrangements, and retains the right to limit or revoke any and all delegated credentialing activities when a delegate fails to meet Molina Healthcare's requirements.

Molina Healthcare's Credentialing Committee retains the right to approve new providers and provider sites and terminate practitioners, providers and sites of care based on requirements in Molina Healthcare Credentialing Policy.

To be delegated for credentialing, IPAs and Provider Groups must:

- Be National Committee for Quality Assurance (NCQA) accredited or certified for credentialing or pass Molina Healthcare's credentialing delegation pre-assessment, which is based on NCQA credentialing standards and requirements for the Medicaid and Medicare programs, with a score of at least 90%.
- Correct deficiencies within mutually agreed upon time frames when issues of non-compliance are identified by Molina Healthcare at pre-assessment
- Agree to Molina Healthcare's contract terms and conditions for credentialing delegates
- Submit timely and complete reports to Molina Healthcare as described in policy and procedure
- Comply with all applicable federal and state laws
- If the IPA or Provider Group subdelegates primary source verification to a Credentialing Verification Organization (CVO), the CVO must be NCQA certified in all ten areas of accreditation.

Non-Discriminatory Credentialing and Recredentialing

Molina Healthcare does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures (e.g. abortions) or patients (e.g. Medicaid or Medicare) in which the practitioner specializes. This does not preclude Molina Healthcare from including in its network practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of members.

Notification of Discrepancies in Credentialing Information

Molina Healthcare will notify the practitioner immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner. Examples include but are not limited to actions on a license, malpractice claims history or board certification decisions. Molina Healthcare is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by law. Please also refer to the section below titled Practitioners Right to Correct Erroneous Information.

Notification of Credentialing Decisions

A letter is sent to every practitioner with notification of the Credentialing Committee or Medical Director decision regarding their participation in the Molina Healthcare network. This notification is sent within two weeks of the decision. Copies of the letters are filed in the practitioner's credentials files. Under no circumstance will notifications letters be sent to the practitioners later than 60 calendar days from the decision.

Confidentiality

All practitioner information obtained during the credentialing process is private and confidential except where otherwise specified by law or at the discretion of the Credentialing Committee or the Molina Healthcare Board. This policy includes both voting and non-voting members of the Credentialing Committee, invited guests of the Credentialing Committee and Molina Healthcare Credentialing staff who is involved in the data collection and file preparation for the credentialing and recredentialing process.

Information, documents and/or evidence created, collected, maintained or otherwise arising out of matters that are under review, or have been reviewed pursuant to these policies, will be kept confidential by all participants except as required by law or at the discretion of the Credentialing Committee or the Molina Healthcare Board, in order to encourage candor and careful assessment necessary to effect peer review and quality assurance.

All members (voting and non-voting) and guests of the Credentialing Committee, or any other committee performing any peer review functions or other individuals who participate in peer review functions will sign a Statement of Confidentiality annually. Members and guests of the Credentialing Committee will not discuss, share or use any information for any purpose other than peer review at Molina Healthcare.

The Director in charge of Credentialing grants access to electronic credentials files only as necessary to complete credentialing work or as required by law. Access to these documents are restricted to authorized staff, Credentialing Committee members, peer reviewers and reporting bodies as authorized by the Credentialing Committee or the Governing Board of Molina. Healthcare Each person is given a unique user ID and password. It is the strict policy of Molina Healthcare that employees keep their passwords confidential and never share their passwords with anyone. All Credentialing employees are prompted to change their passwords into the system every three (3) months.

Minutes, reports and files of Credentialing Committee meetings are stored in secure electronic folders or in locked cabinets in the Credentialing Department and will be protected from discovery under all applicable laws.

Copies of minutes and any other related Credentialing Committee meeting materials will not be allowed to be removed from meetings of peer review committees and Credentialing staff will shred extra sets of information from such meetings. Electronic data and/or information are password protected and Molina Healthcare staff is instructed not to divulge passwords to their co-workers.

Practitioners Rights During the Credentialing Process

Practitioners have the right to review their credentials file at any time. Practitioners are notified of their right in a letter sent to them at the time the initial or recredentialing application is received.

The practitioner must notify the Credentialing Department and request an appointed time to review their file and allow up to seven calendar days to coordinate schedules. A Medical Director and the Director responsible for Credentialing or the Quality Improvement Director will be present. The practitioner has the right to review all information in the credentials file except peer references or recommendations protected by law from disclosure.

The only items in the file that may be copied by the practitioner are documents which the practitioner sent to Molina Healthcare (e.g., the application, the license and a copy of the DEA certificate). Practitioners may not copy documents that include pieces of information that are confidential in nature, such as the practitioner credentialing checklist, the responses from monitoring organizations (i.e. National Practitioner Data Bank, State Licensing Board), and verification of hospital privileges letters.

Practitioners Right to Correct Erroneous Information

Practitioners have the right to correct erroneous information in their credentials file. Practitioners are notified of their right in a letter sent to them at the time the initial or recredentialing application is received.

Molina Healthcare will notify the practitioner immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner. Examples include but are not limited to actions on a license or malpractice claims history. Molina Healthcare is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by law.

The notification sent to the practitioner will detail the information in question and will include instructions to the practitioner indicating:

- Their requirement to submit a written response within ten (10) calendar days of receiving notification from Molina Healthcare.
- In their response, the practitioner must explain the discrepancy, may correct any erroneous information and may provide any proof that is available.
- The practitioner's response must be sent to Molina Healthcare, Inc. Attention Kari Horseman, CPCS, Credentialing Director at PO Box 2470 Spokane WA 99210

Upon receipt of notification from the practitioner, Molina Healthcare will document receipt of the information in the practitioners credentials file. Molina Healthcare will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the practitioners credentials file. The practitioner will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with practitioners' notification, the Credentialing Department will notify the practitioner. The practitioner may then provide proof of correction by the primary source body to Molina Healthcare's Credentialing Department. The Credentialing Department will re-verify primary source information if such documentation is provided.

If the practitioner does not respond within ten (10) calendar days, their application processing will be discontinued and network participation will be denied.

Practitioners Right to be Informed of Application Status

Practitioners have a right, upon request, to be informed of the status of their application. Practitioners applying for initial participation are sent a letter when their application is received by Molina Healthcare and are notified of their right to be informed of the status of their application in this letter.

The practitioner can request to be informed of the status of their application by telephone, email or mail. Molina Healthcare will respond to the request within two (2) working days. Molina Healthcare may share with the practitioner where the application is in the credentialing process to include any missing information or information not yet verified. Molina Healthcare does not share with or allow a practitioner to review references or recommendations, or other information that is peer-review protected.

Credentialing Committee

Molina Healthcare designates a Credentialing Committee to make recommendations regarding credentialing decisions using a peer review process. Molina Healthcare works with the Credentialing Committee to strive to assure that network practitioners are competent and qualified to provide continuous quality care to Molina Healthcare members. A practitioner may not provide care to Molina Healthcare members until the final decision from the Credentialing Committee or in situations of "clean files" the final decision from the Molina Healthcare Medical Director.

The Credentialing Committee is responsible for reviewing and evaluating the qualifications of applicant practitioners and for approving or denying applicants for participation. In addition, the Credentialing Committee reviews Credentialing Policies and Procedures annually and recommends revisions, additions and/or deletions to the policies and procedures. Composed of network practitioners, the committee is responsible for performing peer review of medical information when requested by the Medical Director, and recommending actions based on peer review findings, if needed. The committees report to the Quality Improvement Committee (QIC).

Each Credentialing Committee member shall be immune, to the fullest extent provided by law, from liability to an applicant or practitioner for damages or other relief for any action taken or statements or recommendations made within the scope of the committee duties exercised.

Committee Composition

The Medical Director chairs the Credentialing Committee and appoints all Credentialing Committee members. Each member is required to meet all of Molina Healthcare's credentialing criteria. Credentialing Committee members must be current representatives of Molina Healthcare's practitioner network. The Credentialing Committee representation includes at least five practitioners, one practitioner from each of the following specialties:

- Family Practice or Internal Medicine
- Pediatrics
- OB/GYN
- Surgery

Additionally, surgical specialists and Internal Medicine specialists may participate on the committee as appropriate. Other ad hoc practitioners may be invited to participate when representation of their discipline is needed. Ad hoc committees representing a specific profession (e.g., Behavioral Health Practitioner, Nurse Practitioners, Chiropractors) may be appointed by the chairs to screen applicants from their respective profession and make credentialing recommendations to the Credentialing Committee.

Committee Members Roles and Responsibilities

- Committee members participate in and support the functions of the Credentialing Committee by attending meetings, providing input and feedback and overall guidance of the Credentialing Program.
- Review/approve credentialing program policy and related policies established by Molina Healthcare on an annual basis, or more often as deemed necessary.
- Review and consider each applicant's information based on criteria and compliance requirements. The Credentialing Committee votes to make final decisions regarding credentialing determinations and disciplinary actions.
- Conduct ongoing monitoring of those practitioners approved to be monitored on a "watch status"
- Access clinical peer input when discussing standards of care for a particular type of practitioner when there is no committee member of that specialty.
- Ensure credentialing activities are conducted in accordance with Molina Healthcare's Credentialing Program.
- Review quality improvement findings as part of the recredentialing and the ongoing monitoring process.

Excluded Practitioners

Excluded practitioner means an individual practitioner, or an entity with an officer, director, agent, manager or individual who owns or has a controlling interest in the entity who has been: convicted of crimes as specified in section 1128 of the SSA, excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of section 1128, or has a contractual relationship with an entity convicted of a crime specified in section 1128.

Pursuant to section 1128 of the SSA, Molina Healthcare and its subcontractors may not subcontract with an Excluded Practitioner/Person. Molina Healthcare and its subcontractors shall terminate subcontracts immediately when Molina Healthcare and its subcontractors become aware of such excluded practitioner/person or when Molina Healthcare and its subcontractors receive notice. Molina Healthcare and its subcontractors certify that neither it nor its member/practitioner is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. Where Molina Healthcare and its subcontractors are unable to certify any of the statements in this certification, Molina Healthcare and its subcontractors shall attach a written explanation to this Agreement.

Practitioners/Providers Opting Out of Medicare

If a practitioner/provider opts out of Medicare, that practitioner/provider may not accept Federal reimbursement for a period of two (2) years. Practitioners/providers who are currently opted out of Medicare are not eligible to contract with Molina Healthcare for the Medicare line of business.

Ongoing Monitoring of Sanctions

Molina Healthcare monitors practitioner sanctions between recredentialing cycles for all practitioner types and takes appropriate action against practitioners when occurrences of poor quality is identified.

Medicare and Medicaid sanctions

The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program releases a report every month of individuals and entities that have been excluded from Medicare and Medicaid programs. Within 30 calendar days of its release, Molina Healthcare reviews the report and if a Molina Healthcare network provider is found with a sanction, the practitioner's contract in terminated effective the same date the sanction was implemented.

Sanctions or limitations on licensure

Molina Healthcare monitors for sanctions or limitations against licensure between credentialing cycles for all network practitioners. All practitioners with identified sanctions or limitations on license in the ongoing monitoring process will be immediately placed into the full credentialing process and will be recredentialed early. The practitioner must provide all necessary information to complete the recredentialing process within the requested time-frames or the practitioner will be administratively terminated from the network. The complete recredentialing file will be reviewed at the next scheduled Credentialing Committee meeting for a determination.

Continuous Query (Proactive Disclosure Service)

Molina Healthcare registers all network practitioners with the NPDB/HIPDB Continuous Query program.

Molina Healthcare receives instant notification of all new NPDB and HIPDB reports against the enrolled providers. When a new report is received between recredentialing cycles, the practitioner will be immediately placed into the full credentialing process and will be recredentialed early. The practitioner must provide all necessary information to complete the recredentialing process within the requested time-frames or the practitioner will be administratively terminated from the network. The complete recredentialing file will be reviewed at the next scheduled Credentialing Committee meeting for a determination.

Medicare Opt-Out

Practitioner's participating in Medicare must not be listed on the Medicare Opt-Out report. Molina Healthcare reviews the quarterly opt out reports released from the appropriate Medicare financial intermediary showing all of the practitioners who have chosen to Opt-Out of Medicare. These reports are reviewed within 30 calendar days of their release. If a physician or other practitioner opts out of Medicare, that physician or other practitioner may not accept Federal reimbursement for a period of 2 years. These provider contracts will be immediately terminated for the Molina Medicare line of business.

Range of Actions, Notification to Authorities and Practitioner Appeal Rights

Molina Healthcare uses established criteria in the review of practitioners' performance. All adverse actions taken by the Credentialing Committee are conducted in compliance with the Fair Hearing Plan and the Healthcare Quality Improvement Act of 1986.

Range of actions available

The Molina Healthcare Credentialing Committee can take one of the following actions against practitioners who fail to meet credentialing standards or who fail to meet performance expectations pertaining to quality of patient care:

- Monitor on a Watch Status
- Require formal corrective action
- Denial of network participation
- Termination from network participation
- In cases where the Medical Director determines the circumstances pose an immediate risk to patients, a practitioner may be summarily suspended from participation in the network, without prior notice, pending review and investigation of information relevant to the case.

This applies to all practitioners who are contracted by Molina Healthcare. These actions do not apply to applicants who do not meet basic conditions of participation and are ineligible for participation. The purpose of this policy is to provide a mechanism for implementation of monitoring on watch status, requiring formal corrective action, suspension or termination of Molina Healthcare practitioners.

If at any point a practitioner fails to meet the minimum standards and criteria for credentialing or fails to meet performance expectations with regard to quality of patient care the Credentialing Committee may act to implement one of these actions. Termination may be taken after reasonable effort has been made to obtain all the facts of the matter and the practitioner may be given the opportunity to appeal this decision.

Criteria for Denial or Termination Decisions by the Credentialing Committee

The criteria used by the Credentialing Committee to make a decision to deny or terminate a practitioner from the Molina Healthcare network include, but are not limited to, the following:

1. The practitioner's professional license in any state has ever had any informal or formal disciplinary orders, decisions, agreements, disciplinary actions or other actions including but not limited to, restrictions, probations, limitations, conditions suspensions and revocations.
2. Practitioner has ever surrendered, voluntarily or involuntarily, his or her professional license in any State while under investigation by the State or due to findings by the State resulting from the practitioner's acts, omissions or conduct.
3. Practitioner has any pending statement of charges, notice of proposed disciplinary actions, notice of agency action or the equivalent from any state or governmental professional disciplinary body which based on the judgment of the Credentialing Committee establishes an immediate potential risk to the quality of care or service delivered by the practitioner to Molina Healthcare members.

4. Practitioner has ever had any restrictions, probations, limitations, conditions, suspensions or revocations on their federal Drug Enforcement Agency (DEA) certificate or Controlled Substance Certification or Registration.
5. Practitioner has a condition, restriction or limitation on their license, certification or registration related to an alcohol, chemical dependency, or health condition or if other evidence indicates that the practitioner has an alcohol, chemical dependency problem or health condition and there is no clear evidence and documentation demonstrating that the practitioner has complied with all such conditions, limitations, or restrictions and is receiving treatment adequate to ensure that the alcohol, chemical dependency problem or health condition will not affect the quality of the practitioner's practice.
6. Practitioner has ever had sanctions of any nature taken by any governmental program or professional body including but not limited to, Medicare, Medicaid, Federal Employee Program or any other State or Federal program or agency
7. Practitioner has ever had any denials, limitations, suspensions or terminations of participation of privileges by any health care institution, plan, facility or clinic.
8. Practitioner's history of medical malpractice claims or professional liability claims or settlements reflect what constitutes a pattern of questionable or inadequate treatment or contain what constitutes any gross or flagrant incident or incidents of malpractice.
9. Practitioner has a criminal history, including, but not limited to, any criminal charges, criminal investigations, convictions, no-contest pleas and guilty pleas.
10. Practitioner has ever had involvement in acts of dishonesty, fraud, deceit or misrepresentation that relate to or impact or could relate to or impact the practitioner's professional conduct or the health, safety or welfare of Molina Healthcare members
11. Practitioner has ever engaged in acts which Molina Healthcare, in its sole discretion, deems inappropriate.
12. Practitioner has a pattern of member complaints or grievances in which there appears to be a concern regarding the quality of service provided to Molina Healthcare members.
13. Practitioner has not complied with Molina Healthcare's quality assurance program.
14. Practitioner is found to have rendered a pattern of substandard care or is responsible for any gross or flagrant incident of substandard care.
15. Practitioner has displayed inappropriate patterns of referral, which deviate substantially from reasonably expected patterns of referral.
16. Practitioner makes any material misstatements in or omissions from their credentialing application and attachments.
17. Practitioner has ever rendered services outside the scope of their license.
18. Practitioner has a physical or mental health condition that may impair their ability to practice with the full scope of licensure and qualifications, or might pose a risk of harm on patients.
19. Practitioner's failure to comply with the Molina Healthcare Medical Record Review Guidelines.
20. Practitioner's failure to comply with the Molina Healthcare Site Review or Medical Record Keeping Practice Review Guidelines.

Monitoring on a Committee Watch Status

Molina Healthcare uses the credentialing category "watch status" for practitioners whose initial or continued participation is approved by the Credentialing Committee with follow-up to occur. The Credentialing Committee may approve a practitioner to be monitored on watch status when there are unresolved issues or when the Credentialing Committee determines that the practitioner needs to be monitored for any reason.

When a practitioner is approved on watch status, the Credentialing Department conducts the follow-up according to the Credentialing Committee direction. Any unusual findings are reported immediately to the Molina Healthcare Medical Director to determine if immediate action is necessary. Every unusual finding is reviewed in detail at the next Credentialing Committee meeting for review and determination.

Corrective Action

In cases where altering the conditions of participation is based on issues related to quality of care and/or service, Molina Healthcare may work with the practitioner to establish a formal CAP to improve performance, prior to, or in lieu of suspending or terminating his or her participation status.

A CAP is a written improvement plan, which may include, but is not limited to the following:

- Identifying the performance issues that do not meet expectations
- What actions/processes will be implemented for correction
- Who is responsible for the corrective action
- What improvement/resolution is expected
- How improvements will be assessed
- Scheduled follow-up, monitoring (compliance review, normally not to exceed six months)

Practitioners subject to corrective action will be notified within ten (10) calendar days, via a certified letter from the Medical Director. Such notification will outline:

- The reason for the corrective action
- The CAP

If the corrective actions are resolved, the practitioner's performance may or may not be monitored, as deemed appropriate. If the corrective action(s) are not adequately resolved within the designated time, depending on the circumstances of the case, the Credentialing Committee may recommend that the practitioner continue on an improvement plan, or recommend suspension or termination. All recommendations for termination that result from a lack of appropriate practitioner response to corrective action will be brought to the Credentialing Committee for review and decision.

Summary Suspension

In cases where the Medical Director becomes aware of circumstances that pose an immediate risk to patients, a meeting will be held immediately with Molina Legal Counsel, the Medical Director and the Director of Credentialing. After discussing the facts, the practitioner may be summarily suspended from participation in the network, without prior notice, pending review and investigation of information relevant to the case.

Such summary suspension shall become effective immediately upon imposition, and the Medical Director shall promptly notify the practitioner of the suspension, via a certified letter. Notification will include the following:

- The action being taken
- Effective date of the action
- The reason(s) for the action and/or information being investigated

- Information (if any) required from the practitioner
- The estimated timeline for determining whether or not to reinstate or terminate the practitioner
- Details regarding the practitioners right to request a fair hearing within 30 calendar days (see Fair Hearing Plan policy) and their right to be represented by an attorney or another person of their choice

Upon initiation of the suspension, the Medical Director and credentialing staff will commence investigation of the issues. Findings of the investigation will be presented to the Credentialing Committee. The Credentialing Committee has the authority to implement corrective action, place conditions on the practitioner's continued participation, discontinue the suspension or terminate the practitioner.

Termination

After review of appropriate information, the Credentialing Committee may determine that the practitioner does not meet performance expectations pertaining to quality of care, services or established performance/professional standards. The Credentialing Committee may then vote to terminate the practitioner. The effective date of the termination is determined by the contractual agreement between Molina Healthcare and the affected practitioner.

Within ten (10) calendar days of the Committee's decision, the practitioner is sent written notice of termination, via a certified letter from the Medical Director, which includes the following:

- Effective date of termination
- Reason for termination
- Obligations of the practitioner regarding further care of Molina Healthcare patients/members
- If applicable, details regarding the practitioners right to request a fair hearing within thirty (30) calendar days (see Fair Hearing Plan policy) and their right to be represented by an attorney or another person of their choice

Notification to Authorities

Molina Healthcare will make reports to appropriate authorities as specified in the Fair Hearing Plan Policy when the Credentialing Committee takes or recommends certain Adverse Actions for a Practitioner based upon Unprofessional Conduct including:

- Revocation, termination of, or expulsion from Molina Healthcare provider status.
- Summary Suspension in effect or imposed for more than thirty (30) calendar days.
- Any other final action by Molina Healthcare that by its nature is reportable to the State Licensing Board, the NPDB, and/or HIPDB.

If a Fair Hearing is offered, a certified letter is sent to the practitioner describing the adverse action taken, the reason for the action and notifying the practitioner of their right to a Fair Hearing. A copy of the Fair Hearing Plan Policy is included with the letter. The practitioner is given thirty (30) calendar days to request a Fair Hearing. The practitioner is notified of their right to be represented by an attorney or another person of their choice.

If the practitioner requests a Fair Hearing, the Molina Fair Hearing Plan Policy is followed. A hearing officer is appointed and a panel of individuals appointed by Molina Healthcare to review the appeal. Once the hearing is completed, a written notification of the appeal decision will be sent to the practitioner which will contain the specific reason for the decision.

Within fifteen (15) calendar days of the effective date of the action, the Manager responsible for credentialing reports the action to the following authorities:

- All appropriate state licensing agencies
- National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB)

Fair Hearing Plan Policy

Under State and Federal law, certain procedural rights shall be granted to a provider in the event that peer review recommendations and actions require a report be made to the State Licensing Board, the National Practitioner Data Bank ("NPDB"), and/or the Healthcare Integrity and Protection Data Bank ("HIPDB").

Molina Healthcare, Inc., and its affiliates ("Molina"), will maintain and communicate the process providing procedural rights to providers when a final action by Molina will result in a report to the State Licensing Board, NPDB, and/or HIPDB.

A. Definitions

1. Adverse Action shall mean an action that entitles a provider to a hearing, as set forth in Section B (l)-(3) below.

2. VP, Medical Affairs shall mean the VP, Medical Affairs for the respective Molina affiliate state plan wherein the provider is contracted.

3. Days shall mean calendar days. In computing any period of time prescribed or allowed by this Policy, the day of the act or event from which the designated period of time begins shall not be included.

4. Medical Director shall mean the Medical Director for the respective Molina affiliate state plan wherein the provider is contracted.

5. Molina Plan shall mean the respective Molina affiliate state plan wherein the provider is contracted.

6. Notice shall mean written notification sent by certified mail, return receipt requested, or personal delivery.

7. Peer Review Committee or Credentialing Committee shall mean a Molina Plan committee or the designee of such a committee.

8. Plan President shall mean the Plan President for the respective Molina affiliate state plan wherein the provider is contracted.

9. Provider shall mean physicians, dentists, and other health care practitioners as defined by 42 USC 11151 and Social Security Act § 1861(u).

10. State shall mean the licensing board in the state in which the provider practices.

11. State Licensing Board shall mean the state agency responsible for the licensure of provider.

12. Unprofessional Conduct refers to a basis for corrective action or termination involving an aspect of a provider's competence or professional conduct which is reasonably likely to be detrimental to patient safety or the delivery of quality care. Unprofessional conduct does not refer to instances where a provider violates a material term of the provider's contract with a Molina Plan.

B. Grounds for a Hearing

Grounds for a hearing exist whenever the Peer Review Committee or Credentialing Committee takes or recommends any of the following Adverse Actions for a provider based upon Unprofessional Conduct:

1. Revocation, termination of, or expulsion from Molina Healthcare provider status when such revocation, termination, or expulsion is reportable to the State Licensing Board, NPDB, and/or HIPDB.

2. Suspension, reduction, limitation, or revocation of authority to provide care to Molina Healthcare members.

3. Any other final action by Molina Healthcare that by its nature is reportable to the State Licensing Board, NPDB, and/or HIPDB.

C. Notice of Action

If the Peer Review Committee and/or Credentialing Committee have recommended an Adverse Action, the Committee shall give written notice to the provider by certified mail with return receipt requested. The notice shall:

1. State the reasons for the action;

2. State any Credentialing Policy provisions that have been violated;

3. Advise the provider that he/she has the right to request a hearing on the proposed Adverse Action;

4. Advise the provider that any request for hearing must be made in writing within thirty (30) days following receipt of the Notice of Action, and must be sent to the respective Molina Healthcare Plan Medical Director by certified mail, return receipt requested, or personal delivery;

5. Advise the provider that he/she has the right to be represented by an attorney or another person of their choice.

6. Advise the provider that the request for a hearing ***must*** be accompanied by a check in the amount of $1,000.00 as a deposit for the administrative expenses of the hearing and specify that this amount will be refunded if the Adverse Action is overturned;

7. State that the proposed action or recommendation, if adopted, must be reported pursuant to State and Federal law; and

8. Provide a summary of the provider's hearing rights or attach a copy of this Policy.

D. Request for a Hearing - Waiver

If the provider does not request a hearing in writing to the VP, Medical Affairs within thirty (30) days following receipt of the Notice of Action, the provider shall be deemed to have accepted the action or recommendation of the Peer Review Committee and/or Credentialing Committee, and such action or recommendation shall be submitted to the VP, Medical Affairs for final decision. In the event that a timely written Request for Hearing is received, a Hearing Officer and/or hearing panel shall be appointed as set forth below and the Peer Review Committee and/or Credentialing Committee shall provide the provider with a Notice of Hearing and Statement of Charges consistent with this Policy.

A provider who fails to request a hearing within the time and in the manner specified above waives his or her right to any hearing to which he or she might otherwise have been entitled. If the provider waives his or her right to any hearing by failing to request a hearing within the time and in the manner specified above, the recommendation of the Peer Review Committee and/or Credentialing Committee taking or recommending the Adverse Action shall be forwarded to the VP, Medical Affairs for final approval. In the event of a submittal to the VP, Medical Affairs upon the provider's waiver as set forth herein, the Peer Review Committee and/or Credentialing Committee may submit to the VP, Medical Affairs additional information relevant to its recommended Adverse Action to be considered by the VP, Medical Affairs in accepting or rejecting the recommended Adverse Action.

E. Appointment of a Hearing Committee

1. Composition of Hearing Committee

The VP, Medical Affairs /Plan President shall select the individuals to serve on the Hearing Committee. The Hearing Committee shall consist of individuals who are not in direct economic competition with the subject provider; who shall gain no direct financial benefit from the outcome of the hearing; and, who shall have not acted as accuser, investigator, fact finder, initial decision maker or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. General knowledge of the matter involved shall not preclude a physician from serving as a member of the panel.

The panel shall consist of three or more providers and shall include, whenever feasible, at least one individual practicing the same specialty as the affected provider. In the event providers are not available to sit as Hearing Committee members, physicians from the community may be substituted by the Medical Director.

2. Scope of Authority

The Hearing Committee shall have the authority to interpret and apply this Policy insofar as it relates to its powers and duties.

3. Responsibilities

The Hearing Committee shall:

a. Evaluate evidence and testimony presented.

b. Issue a decision accepting, rejecting, or modifying the decision of the Peer Review Committee and/or Credentialing Committee.

c. Maintain the privacy of the hearing unless the law provides to the contrary.

4. Vacancies

In the event of a vacancy in a hearing panel after a hearing has commenced, the remaining panel members may continue with the hearing and determination of the controversy, unless the parties agree otherwise.

5. Disclosure and Challenge Procedures

Any person appointed to the Hearing Committee shall disclose to the VP, Medical Affairs/Plan President any circumstance likely to affect impartiality, including any bias or a financial or personal interest in the result of the hearing or any past or present relationship with the parties or their representatives. The Hearing Officer may remove any person appointed to the Hearing Committee if the Hearing Officer believes that the person is unable to render an impartial decision.

F. Hearing Officer

1. Selection

The VP, Medical Affairs and/or Plan President shall appoint a Hearing Officer, who may be an attorney. The Hearing Officer shall gain no direct financial benefit from the outcome of the hearing, shall not act as a prosecuting officer or advocate, and shall not be entitled to vote.

2. Scope of Authority

The Hearing Officer shall have the sole discretion and authority to:

a. Exclude any witness, other than a party or other essential person.

b. Determine the attendance of any person other than the parties and their counsel and representatives.

c. For good cause shown to postpone any hearing upon the request of a party or upon a Hearing Committee's own initiative, and shall also grant such postponement when all of the parties agree thereto.

3. Responsibilities

The Hearing Officer shall:

a. Guide the hearing process, including endeavoring to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner;

b. Ensure that proper decorum is maintained;

c. Be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing;

d. Issue rulings pertaining to matters of law, procedure and the admissibility of evidence;

e. Issue rulings on any objections or evidentiary matters;

f. Discretion to limit the amount of time;

g. Assure that each witness is sworn in by the court reporter;

h. May ask questions of the witnesses (but must remain neutral/impartial);

i. May meet in private with the panel members to discuss the conduct of the hearing;

j. Remind all witnesses at the conclusion of their testimony of the confidentiality of the hearing;

k. Participate in the deliberations of the Hearing Committee as a legal advisor, but shall not be entitled to vote; and

l. Prepare the written report.

G. Time and Place of Hearing

Upon receipt of a Request for Hearing, the VP, Medical Affairs and/or Plan President shall schedule and arrange for a hearing. VP, Medical Affairs and/or Plan President shall give notice to the affected provider of the time, place and date of the hearing, as set forth below. The date of commencement of the hearing shall be not less than thirty (30) days from the date of the Notice of the Hearing, and not more than sixty (60) days from the date of receipt of the Request for Hearing. Notwithstanding the above timeframes, the parties may agree to extensions, or the Hearing Officer may grant an extension on a showing of good cause. If more than one meeting is required for a hearing, the Hearing Officer shall set the date, time, and location for additional meetings.

H. Notice of Hearing

The Notice of Hearing shall contain and provide the affected provider with the following:

1. The date, time and location of the hearing.

2. The name of the Hearing Officer.

3. The names of the Hearing Committee members.

4. A concise statement of the affected provider's alleged acts or omissions giving rise to the Adverse Action or recommendation, and any other reasons or subject matter forming the basis for the Adverse Action or recommendation which is the subject of the hearing.

5. The names of witnesses, so far as they are then reasonably known or anticipated, who are expected to testify on behalf of the Peer Review Committee and/or Credentialing Committee, provided the list may be updated as necessary and appropriate, but not later than ten (10) days prior to the commencement of the hearing.

6. A list of all documentary evidence forming the bases of the charges reasonably necessary to enable the provider to prepare a defense, including all documentary evidence which was considered by the Peer Review Committee and/or Credentialing Committee in recommending the Adverse Action.

Except with regard to the disclosure of witnesses, as set forth above, the Notice of Hearing may be amended from time to time, but not later than the close of the case at the conclusion of the hearing by the Hearing Committee. Such amendments may delete, modify, clarify or add to the acts, omissions, or reasons specified in the original Notice of Hearing.

I. Pre-Hearing Procedures

1. The provider shall have the following pre-hearing rights:

   a. To inspect and copy, at the provider's expense, documents upon which the charges are based which the Peer Review Committee and/or Credentialing Committee have in its possession or under its control; and

   b. To receive, at least thirty (30) days prior to the hearing, a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the provider to prepare a defense, including all evidence that was considered by the Peer Review Committee and/or Credentialing Committee in recommending Adverse Action.

2. The Hearing Committee shall have the following pre-hearing right:

   To inspect and copy, at Molina HealthCare's expense, any documents or other evidence relevant to the charges which the provider has in his or her

possession or control as soon as practicable after receiving the hearing request.

3. The Hearing Officer shall consider and rule upon any request for access to information and may impose any safeguards required to protect the peer review process, privileges and ensure justice. In so doing, the Hearing Officer shall consider:

   a. Whether the information sought may be introduced to support or defend the charges;

   b. The exculpatory or inculpatory nature of the information sought, if any;

   c. The burden attendant upon the party in possession of the information sought if access is granted; and

   d. Any previous requests for access to information submitted or resisted by the parties.

4. The provider shall be entitled to a reasonable opportunity to question and object to or challenge the impartiality of members of the Hearing Committee and the Hearing Officer. Challenges to the impartiality of any Hearing Committee member or the Hearing Officer shall be ruled on by the Hearing Officer.

5. It shall be the duty of the provider, the Peer Review Committee and/or Credentialing Committee to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

6. Failure to disclose the identity of a witness or produce copies of all documents expected to be produced at least ten (10) days before the commencement of the hearing shall constitute good cause for a continuance or limitation of the evidence or the testimony if deemed appropriate by the Hearing Officer.

7. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable physicians or patients, other than the provider under review, or to information, interviews, reports, statements, findings and conclusions resulting from studies or other data prepared specifically to be submitted for review purposes made privileged by operation of State.

J. Conduct of Hearing

1. Rights of the Parties

   Within reasonable limitations, and as long as these rights are exercised in an efficient and expeditious manner, both sides at the hearing may:

   a. Call and examine witnesses for relevant testimony.

   b. Introduce relevant exhibits or other documents.

c. Cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues.

d. Otherwise rebut evidence.

e. Have a record made of the proceedings.

f. Submit a written statement at the close of the hearing.

g. Receive the written recommendation of the Hearing Officer or Hearing Committee, including a statement of the basis for the recommendations, upon completion of the hearing.

The provider may be called by the Peer Review Committee and/or Credentialing Committee and examined as if under cross-examination.

2. Course of the Hearing

a. Each party may make an oral opening statement.

b. The Peer Review Committee and/or Credentialing Committee shall call any witnesses and present relevant documentary evidence to support its recommendation.

c. The affected provider may then call any witnesses and present relevant documentary evidence supporting their defense.

d. The Hearing Committee or Officer has the discretion to vary the course of the hearing, but shall afford a full and equal opportunity to all parties for the presentation of material and relevant evidence and for the calling of witnesses.

e. The Hearing Committee shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence shall not be necessary. All evidence shall be taken in the presence of the entire Hearing Committee and all of the parties, except when agreed to by the parties, or determined by the Hearing Officer.

3. Use of Exhibits

a. Exhibits, when offered by either party, may be received into evidence by the Hearing Committee as ruled upon by the Hearing Officer.

b. A description of the exhibits in the order received shall be made a part of the record.

4. Witnesses

a. Witnesses for each party shall submit to questions or other examination.

b. The Hearing Officer shall have the power to sequester witnesses (exclude any witness, other than a party or other essential person, during the testimony of any other witness). The names and addresses of all

witnesses and a description of their testimony in the order received shall be made a part of the record.

c. The Hearing Committee may receive and consider the evidence of witnesses by affidavit, but shall give it only such weight as the Hearing Committee deems it is entitled to after consideration of any objection made to its admission.

d. The party producing such witnesses shall pay the expenses of their witnesses.

5. Rules for Hearing:

a. Attendance at Hearings

Only those persons having a direct interest in the hearing are entitled to attend the hearing. This means that the hearing will be closed except for the parties and their representatives. The only exception is when good cause is shown satisfactory to the Hearing Officer that it is necessary in the interest and fairness of the hearing to have others present.

b. Communication with Hearing Committee

There shall be no direct communication between the parties and the Hearing Committee other than at the hearing, unless the parties and the Hearing Committee agree otherwise. Any other oral or written communication from the parties to the Hearing Committee shall be directed to the Hearing Officer for transmittal to the Hearing Committee.

c. Interpreter

Any party wishing to utilize an interpreter shall make all arrangements directly with the interpreter and shall assume the costs of the services.

K. Close of the Hearing

At the conclusion of the hearing, the Hearing Officer shall dismiss all parties and participate in the deliberations of the Hearing Committee. The Hearing Committee shall render its final decision by a majority vote, including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached to the Hearing Officer.

Within thirty (30) days of the conclusion of the deliberations, the Hearing Officer shall issue a written report including the following:

1. A summary of facts and circumstances giving rise to the hearing.

2. A description of the hearing, including:

a. The panel members' names and specialties;

b. The Hearing officer's name;

c. The date of the hearing;

d. The charges at issue; and

e. An overview of witnesses heard and evidence.

3. The findings and recommendations of the Hearing Committee.

4. Any dissenting opinions desired to be expressed by the hearing panel members.

Final adjournment of the Hearing Committee shall occur when the Hearing Officer has mailed or otherwise delivered the written report.

L. Burden of Proof

In all hearings it shall be incumbent on the Peer Review Committee and/or Credentialing Committee taking or recommending an Adverse Action to come forward initially with evidence in support of its action or decision. Thereafter, the provider who requested the hearing shall come forward with evidence in their support.

The burden of proof during a hearing shall be as follows:

The Peer Review Committee or Credentialing Committee taking or recommending the Adverse Action shall bear the burden of persuading the Hearing Committee that its action or recommendation is reasonable and warranted. The term "reasonable and warranted" means within the range of alternatives reasonably available to the Peer Review Committee and/or Credentialing Committee taking or recommending Adverse Action under the circumstances and not necessarily that the action or recommendation is the only measure or the best measure that could have been taken or formulated.

M. Provider Failure to Appear or Proceed

Failure, without good cause, of the provider to personally attend and proceed at a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

N. Record of the Hearing/Oath

A court reporter shall be present to make a record of the hearing proceedings and the pre-hearing proceedings, if deemed appropriate by the Hearing Officer. The cost of attendance of the reporter shall be borne by Molina Healthcare, but the cost of the transcript, if any, shall be borne by the party requesting it. The Hearing Officer shall be required to order that all oral evidence be taken by oath administered by a person lawfully authorized to administer such oath.

O. Representation

Each party shall be entitled to representation by an attorney at law, or other representative at the hearing, at their own expense, to represent their interests, present their case, offer materials in support thereof, examine witnesses, and/or respond to appropriate questions.

P. Postponements

The Hearing Officer, for good cause shown, may postpone any hearing upon the request of a party or the Hearing Committee.

Q. Notification of Finding

The Hearing Office shall serve a copy of the written report outlining the basis of the Hearing Committee's decision to the Medical Director, the Peer Review Committee and/or Credentialing Committee imposing the Adverse Action, and the affected provider.

R. Final Decision

Upon receipt of the Hearing Committee's decision, VP, Medical Affairs /Plan President shall either adopt or reject the Hearing Committee's decision. The VP, Medical Affairs /Plan President's action constitutes the final decision.

S. Reporting

In the event the VP, Medical Affairs /Plan President adopts the proposed decision of the Peer Review Committee and/or Credentialing Committee taking or recommending the Adverse Action, Molina Healthcare will submit a report to the State Licensing Board, NPDB, and/or HIPDB, as required. Reports shall be made in accordance with the Credentialing Program Policy.

T. Exhaustion of Internal Remedies

If any of the above Adverse Actions are taken or recommended, the provider must exhaust the remedies afforded by this Policy before resorting to legal action.

Section 13.

COMPLAINTS, GRIEVANCES AND APPEALS PROCESS

Molina Healthcare members or member's personal representatives have the right to file a grievance and submit an appeal through a formal process. All grievances and appeals must first be submitted to Molina Healthcare for resolution, but may later be appealed to HFS. However, the filing of a grievance does not preclude the member from filing a complaint with HFS.

This section addresses the identification, review and resolution of member grievances and appeals. Below are Molina Healthcare's Member Grievance and Appeals Process.

Definitions

Appeal: An Appeal is a request for Molina Healthcare to review a decision made. Appeals may be made by members (or designated representative) and by providers.

Clinical Peer: Clinical peer means a health care professional who is in the same profession and the same or similar specialty as the health care provider who typically manages the medical condition, procedures, or treatment under review.

Complaint: The reporting of an issue or concern submitted to Molina Healthcare by a provider regarding any aspect of Molina Healthcare as it relates to the provider that is recorded in Molina Healthcare's complaint log, and resolved by Molina Healthcare where the concern is not related to a member and not considered a formal grievance.

Expedited Appeal: An Expedited Appeal is a request for Molina Healthcare to review a decision made where the decision is related to one of the following health care services, referrals or procedures:

I. Services for a member with an ongoing course of treatment where the denial of such services could significantly increase the risk to the member's health; or where a treatment, service or;
II. Referral for services or procedures where the denial of request could significantly increase the risk a member's health

Grievance: Grievance means any written complaint submitted to Molina Healthcare by or on behalf of a member regarding any aspect of Molina Healthcare relative to the member, but shall not include any complaint by or on behalf of a provider.

Grievance Committee: Grievance Committee means individuals who have been appointed by Molina Healthcare to respond to grievances which have been filed on appeal from Molina Healthcare's simplified complaint process.

Second opinion

If a member does not agree with their provider's plan of care, they have the right to a second opinion from another provider. Member can call Member Services to find out how to get a second opinion.

Member Grievance Process

If a member is unhappy with the service from Molina Healthcare or providers contracted with Molina Healthcare, they may file a grievance by contacting Member Services toll-free at (855) 766-5462. They can also write to us at:

Molina Healthcare of Illinois, Inc.
Attn: Appeals and Grievance, Complaints Dept.
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523

Or via fax: (630) 571-1220

All grievances, whether oral or written, are documented and logged by the Appeals and Grievances Department in all appropriate Systems. Members are notified of their grievance and appeal rights and the different levels of grievances and appeals through various general

communications including, but not limited to, the member handbook, Evidence of Coverage and Disclosure, member newsletters and Molina Healthcare's website: www.molinahealthcare.com

Members may identify an individual, including an attorney or provider, to serve as a personal representative to act on their behalf at any stage during the grievance and appeals process. If under applicable law, a person has authority to act on behalf of a member in making decision related to health care or is a legal representative of the member, Molina Healthcare will treat such person as a personal representative. Providers are able to submit a grievance on behalf of a member. Providers should obtain a signed authorization from the member prior to submitting a grievance.

The member (or designated representative) shall have the right to attend and participate in the formal grievance proceedings.

When needed, members are given reasonable assistance in completing forms and taking other procedural steps, including translation services for members with limited English proficiency or other limitations, e.g., hearing impaired, requiring communication support.

Members will continue any and all benefits while in the Grievance and Appeals process unless previously disenrolled.

Any issues related to a clinical denial and/or appeal of a coverage decision is referred to the Utilization Management Department to review the medical necessity aspects of the request. Any grievance or appeal with Potential Quality of Clinical Care (PQOC) are referred to the QI Department for further investigation and handling Additionally, any identified issue related to the Privacy and Confidentiality of Protected Health Information (PHI) is referred to the Privacy Officer.

Molina Healthcare has an organized grievance process to ensure thorough, appropriate and timely resolution to members' grievances and to aggregate and trend reasons for grievances in order to take action to reduce future occurrence. All grievances are entered into the Appeals and Grievance log by the individual taking the call or receiving the communication. If the individual receiving the communication cannot resolve the issue, the issue is assigned to the appropriate department or individual for resolution. Once the issue is resolved, the issue "manager" will close the call and document the outcome. Once a grievance is received, it will not be closed in the Appeals and Grievance log until the member has been notified of the outcome, has had the right to appeal if appropriate and the final disposition documented.

Grievance documentation will include the following :

- The substance of the grievance and actions taken
- The investigation of the substance of the grievance, including any aspects of clinical care involved
- The outcome/resolution
- The documentation of notification to the member of the disposition of the grievance and the right to appeal, as appropriate

Members who are not satisfied with Molina Healthcare's resolution of any grievance may appeal the decision to HFS at the following location:

201 South Grand Ave. East
Springfield, Illinois 62763-0001
(217) 782-1200

HFS may also be contacted electronically at http://www.hfs.illinois.gov

Grievance Timelines

A Written and signed acknowledgement of the grievance is sent to the member within three (3) business days of receipt. A determination will be made by the Grievance Committee expeditiously.

Molina Healthcare will provide the member (or designated representative) written notification of determination. Where grievance was final appeal step, Molina Healthcare will also provide notification of the availability of the Illinois State Department of Insurance to respond to member inquires.

Appeals

Appeals may be submitted by members (or designated representative) or by providers (PCPs or other providers rendering care). Members and providers are notified of the following at the time they are notified of Molina Healthcare's decision in connection to a requested healthcare service or claim for service:

- Their right to appeal the decision
- The process by which the appeal process is initiated
- The Molina Healthcare customer service phone number where more information regarding the appeal process can be obtained
- The availability of the Illinois State Department of Insurance

An Appeal must be filed within sixty (60) calendar days of receipt of the notice of the Health Plan's action. The member can call (855) 766-5462 to file an appeal.

Written appeals may be submitted to:

Molina Healthcare of Illinois, Inc.
Attn: Appeals and Grievance, Complaints Dept.
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523

Or

Via Fax: (630) 571-1220

Molina Healthcare will designate a clinical peer to review appeals. No one reviewing an appeal may have had any involvement in the initial determination that is the subject of the appeal.

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

If the appealing party is dissatisfied with the outcome of an appeal, an External Independent Review may be requested for non-waiver services.

Members who are not satisfied with Molina Healthcare's final resolution of any appeal may further appeal the decision to HFS at the following location:

201 South Grand Ave. East
Springfield, Illinois 62763-0001
(217) 782-1200

HFS may also be contacted electronically at http://www.hfs.illinois.gov

Any issues related to a clinical denial and/or appeal of a coverage decision is referred to the Utilization Management Department to review the medical necessity aspects of the request. Any grievance or appeal with PQOC are referred to the Quality Improvement Department for further investigation and handling. Additionally, any identified issue related to PHI is referred to the Privacy Officer.

Expedited Appeals Process and Timeline

Expedited appeals may be submitted in writing to the address or fax number above.

Upon submission of appeal, Molina Healthcare will notify the party filing the appeal as soon as possible, and within no more than twenty-four (24) hours after receipt, of all information that is required to evaluate the appeal. Molina Healthcare will render a decision within twenty four (24) hours of receiving the required information.

Molina Healthcare will notify the party filing the appeal, the member (or designated representative) the member's PCP, and any health care provider who recommended the care service involved in the appeal orally of its decision. Oral notification will be followed up by a written notice of determination.

Standard Appeals Process and Timeline

Standard appeals may be submitted in writing to the address or fax number above.

Upon submission of appeal, Molina Healthcare will notify the party filing the appeal, within three (3) business days, of all information that is required to evaluate the appeal. Molina Healthcare will render a decision on the appeal within fifteen (15) business days after receipt of the required information.

Molina Healthcare will notify the party filing the appeal, the member (or designated representative) the member's PCP, and any health care provider who recommended the care service involved in the appeal orally of its decision. Oral notification will be followed up by a written notice of determination.

If the party filing the appeal is dissatisfied with Molina Healthcare's determination, an External Independent Review or a State Medicaid hearing may be requested.

External Independent Review

An external independent review may be requested by a non-waiver member (or designated representative) or by a provider (PCP or other provider rendering service). The party seeking an external independent review must notify Molina Healthcare of this request in writing at the address above.

Requests for External Independent Review must be submitted within (30) days of receipt of written notification of a denied appeal. Written request must be accompanied by any information or documentation to support the member's request for covered service or claim for a covered service.

Molina Healthcare will do the following within thirty (30) days of receipt of request for External Independent Review:

- Provide mechanism for the joint selection (involving Molina Healthcare and the member, member's physician, or other health care provider) of an external independent reviewer.
- Forward the selected independent reviewer all medical records and supporting documentation, a description of the applicable issues, and a statement of Molina Healthcare's decision along with the criteria used and medical and clinical reasons for the decision.

Within five (5) days after receiving all of the necessary information, the independent reviewer will evaluate and analyze the case and render a decision. The decision by the independent review is final. If the reviewer determines the health care service to be medically appropriate, Molina Healthcare will pay for the service.

The independent reviewer will not be informed of the specific identity of the member.

The independent reviewer must be a clinical peer and have no direct affiliation to Molina Healthcare or financial interest in connection with the case in question.

Expedited External Independent Review

Molina Healthcare will resolve all external independent review as expeditiously as possible. Molina Healthcare will make a determination and provide written notification of the determination within no more than twenty-four (24) hours after the receipt of all necessary information when a delay would significantly increase the risk to a member's health or when extended health care services for a member undergoing a course of treatment prescribed by a health care provider are at issue.

Review by HFS

Members not satisfied with the determination of the Independent reviewer may request review by Healthcare and Family Services. Parties to the review include the Plan and the member (or designated representative).

Requests for HFS review must be filed within thirty (30) days of the date of the initial action that is being review. The request must be sent to state of Illinois Department of Healthcare and Family Services (HFS) at the following address:

Illinois Department of Healthcare and Family Services
Bureau of Contract Management
Prescott E. Bloom Building
201 S. Grand Avenue East
Springfield, IL 62763
(217) 782-1200

Provider Dispute

The processing, payment or nonpayment of a claim by Molina Healthcare shall be classified as a Provider Dispute and shall be sent to the following address:

Molina Healthcare of Illinois
Attention: Provider Disputes
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523

All provider disputes for payment or non-payment must be submitted to Molina Healthcare within ninety (90) calendar days.

Reporting

All Grievance/Appeal data, including practitioner specific data, is reported quarterly to Member/Provider Satisfaction Committee by the Department Managers for review and recommendation. A Summary of the results is reported to the Executive Quality Improvement Committee (EQIC) quarterly. Annually, a quantitative/qualitative report will be compiled and presented to the Member/Provider Satisfaction Committee (MPSC) and EQIC by the chairman of MPSC to be included in the organization's Grand Analysis of customer satisfaction and assess opportunities for improvement.

Appeals and Grievances will be reported to the State quarterly. Grievance and Appeals reports will be reviewed monthly by the Credentialing Coordinator for inclusion in the trending of ongoing sanctions, complaints and quality issues.

Record Retention

Molina Healthcare will maintain all grievance and related appeal documentation on file for a minimum of six (6) years. In addition to the information documented electronically via the Appeals and Grievances log or maintained in other electronic files, Molina Healthcare will retain copies of any written documentation submitted by the provider pertaining to the grievance/appeal process. Provider shall maintain records for a period not less than ten (10) years from the termination of the Model Contract and retained further if the records are under review or audit until the review or audit is complete. (Provider shall request and obtain Health Plan's prior approval for the disposition of records if Agreement is continuous).

Section 14.

MEDICAL GROUP/IPA OPERATIONS

This section contains information specific to medical groups and Independent Practice Associations (IPA) contracted with Molina Healthcare to provide medical care to members, and outlines Molina Healthcare's delegation criteria and capitation reimbursement models. Molina Healthcare will delegate certain administrative responsibilities to the contracted medical group/IPA upon meeting all of Molina Healthcare's delegation criteria. Provider capitation reimbursement models employed by Molina Healthcare range from fee-for-service to full risk capitation.

Delegation of Administrative Functions

Administrative services which may be delegated to IPAs, medical groups, or other organizations include:

- Claims payment
- Credentialing
- Utilization Management (UM)

Credentialing functions may be delegated to capitated or non-capitated entities, which meet NCQA criteria for credentialing functions. UM and/or Claims payment responsibility is generally only delegated to capitated entities.

Note: The member's Molina Healthcare ID card will identify which group the member is assigned. If Claims payment and/or UM has been delegated to the group, the ID card will show the delegated group's remit to address and phone number for referrals and prior authorizations (See section 2) where a sample Molina Healthcare ID card will be shown at a later date.

For a quick reference, the following table reflects the Claims and Referral/Authorization contact information for all medical groups/IPAs currently delegated for Claims payment and/or UM functions.

Medical Group/IPA Full Name	ID card Acronym	Claims Remit to Address	UM Referral/ Authorization Phone #

Delegation Criteria

Molina Healthcare is accountable for all aspects of the member's health care delivery, even when it delegates specific responsibilities to sub-contracted medical groups/IPAs. Molina Healthcare's Delegation Oversight Committee (DOC) must approve all delegation and sub-delegation arrangements.

Credentialing

To be delegated for credentialing, medical groups/IPAs must:

- Be accredited by the National Committee for Quality Assurance (NCQA) for credentialing or pass Molina Healthcare's credentialing pre-assessment, which is based on NCQA credentialing standards, with a score of at least 80%
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina Healthcare
- Agree to Molina Healthcare's contract terms and conditions for credentialing delegates
- Submit timely and complete credentialing reports to Molina Healthcare
- Comply with all applicable federal and state laws
- When key specialists, as defined by Molina Healthcare, contracted with IPA or group terminate, they shall provide Molina Healthcare with a letter of termination according to contractual agreements and the information necessary to notify affected members

Note: If the medical group/IPA sub-delegates primary source verification to a Credentialing Verification Organization (CVO), the CVO must be NCQA accredited in all ten areas of accreditation. If the medical group/IPA sub-delegates to a hospital credentialing department, the hospital credentialing department must either be NCQA accredited, or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited with full compliance in the medical staff service standards.

A medical group/IPA may request credentialing delegation from Molina Healthcare through Molina Healthcare's Delegation Manager (or this process can be initiated by the medical group/IPA's Contract Manager). Molina Healthcare will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the DOC for review. Final decision to delegate the credentialing process is based on the medical group/IPAs ability to meet Molina Healthcare's standards and criteria for delegation.

Utilization Management

To be delegated for UM, medical groups/IPAs must:

- Have a UM program that has been operational at least one year prior to delegation
- Be NCQA accredited for utilization management or pass Molina Healthcare's UM pre-assessment, which is based on NCQA credentialing standards, with a score of at least 80%

- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina Healthcare
- Agree to Molina Healthcare's contract terms and conditions for UM delegates
- Submit timely and complete UM delegate reports to Molina Healthcare
- Comply with the standard Transactions and Code Sets requirements for authorization requests and responses using the formats required by HIPAA
- Comply with all applicable federal and state laws

A medical group/IPA may request UM delegation from Molina Healthcare through Molina Healthcare's Provider Services Contract Manager. Molina Healthcare will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the DOC for review. Final decision to delegate UM is based on the medical group/IPAs ability to meet Molina Healthcare's standards and criteria for delegation.

Claims

To be delegated for Claims, IPAs and Provider Groups must do the following:

- Have a capitation contract with Molina Healthcare and be in compliance with the financial reserves requirements of the contract
- Be delegated for UM by Molina Healthcare
- Have an automated Claims payment system with eligibility, authorization, and Claims adjudication
- Have a Claims delegation pre-assessment completed by Molina Healthcare to determine compliance with all regulatory requirements for Claims payment, such as the Claims for emergency services, and the payment of interest on Claims not paid within Illinois regulated timeframes
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina Healthcare
- Protect the confidentiality of all Claims information as required by law
- Have a system capable of providing Molina Healthcare with the encounter data required by the state in a format readable by Molina Healthcare
- Agree to Molina Healthcare's contract terms and conditions for Claims delegates
- Submit timely and complete Claims delegate reports to Molina Healthcare
- Within forty-five (45) days of the end of the month in which care was rendered, provide Molina Healthcare with the encounter data required by the state in a format compliant with HIPAA requirements
- Provide additional information as necessary to load encounter data within thirty (30) days of Molina Healthcare's request
- Comply with the standard Transactions and Code Sets requirements for accepting and sending electronic health care Claims information and remittance advice statements using the formats required by HIPAA
- Comply with all applicable federal and state laws
- When using Molina Healthcare's contract terms to pay for services rendered by providers not contracted with IPA or group, follow Molina Healthcare's Claims policies and guidelines, such as the retroactive authorization policy and guidelines for Claims adjustments and review of denied Claims

A medical group/IPA may request Claims delegation from Molina Healthcare through Molina Healthcare's Delegation Manager (or this process can be initiated by the medical group/IPA's Contract Manager). Molina Healthcare will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the

pre-assessment are submitted to the DOC for review. Final decision to delegate Claims is based on the medical group/IPA's ability to meet Molina Healthcare's standards and criteria for delegation.

Quality Improvement/Preventive Health Activities

Molina Healthcare will not delegate quality improvement to provider organizations. Molina Healthcare will include all network providers, including those in medical groups/IPAs who are delegated for other functions (Claims, Credentialing, UM) in its quality improvement program activities and preventive health activities. Molina Healthcare encourages all contracted provider organizations to conduct activities to improve the quality of care and service provided by their organization. Molina Healthcare would appreciate receiving copies of studies conducted or data analyzed as part of the medical group/IPAs quality improvement program.

Delegation Reporting Requirements

Medical groups/IPAs, contracted with Molina Healthcare and delegated for various administrative functions, must submit monthly reports to Molina Healthcare's FTP site within the timeline indicated by the health plan. For a copy of Molina Healthcare's current delegation reporting requirements, please contact your Molina Healthcare Provider Services Contract Manager.

Section 15.

CULTURAL COMPETENCY

Background

The Cultural Competency Plan exists to ensure the delivery of culturally competent services and ensure the provision of Linguistic Access and Disability-related Access to all members including those with limited English Proficiency. The plan is based on guidelines outlined in National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care, published by the US Department of Health and Human Services (HHS), Office of Minority Health (OMH). The Cultural Competency Plan describes how the individuals and systems within the Organization will effectively provide services to people of all cultures, races, ethnic backgrounds 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.

Training of employees and providers, and quality monitoring are the cornerstones of successful culturally competent service delivery. For that reason, the cultural competency program is integrated into the overall provider training and quality monitoring programs. An integrated quality approach is aimed at enhancing 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 Healthcare offers educational opportunities in cultural competency concepts for providers on a regular basis. This is a summary of the Cultural Competency Plan; providers may use links on the Molina Healthcare website to obtain the full Cultural Competency Plan.

Cultural Competency trainings are offered to providers and supporting staff. Cultural Competency Training programs are also available to Community Based Organizations.

Provider training is conducted concurrent with and integrated into provider orientation with annual reinforcement training. Additional training reinforcement is provided through continuing medical education (CME) monographs developed by the health plan, and periodically accompanying provider communications. Cultural Notes, a monthly newsletter publication, is emailed to interested providers highlighting important cultural customs relevant to plan members.

Training is provided in modules delivered through a variety of methods including, but not limited to one or more of the following:

- Written materials –provider manual
- Access to enduring reference materials available through health plan representatives and the Molina Healthcare website
- Integration of cultural competency concepts into provider communications
- CME

Integrated Quality Improvement – Ensuring Access

Molina Healthcare ensures member access to language services such as oral interpreting, written translation and access to programs and services that are congruent with cultural norms and provide quality care.

Molina Healthcare provides oral interpreting of written information to any plan member who speaks any non-English language regardless of whether that language meets the threshold of a prevalent non-English language. Molina Healthcare notifies plan members of the availability of oral interpreting services and informs them of how to access oral interpreting services. Members are informed that there is no charge for interpreting and translation services.

Members may also request written member materials in alternate languages and formats, which are provided within fourteen (14) business days. Such congruency with member populations leads to better communication, understanding and member satisfaction.

Key member information, including appeals and grievance forms, are also available in threshold languages on the Molina Healthcare member website.

Program and Policy Review Guidelines

Molina Healthcare conducts assessments at regular intervals of the following information in order to ensure its programs are most effectively meeting the needs of its members and providers:

- Annual review of membership demographics (preferred language, ethnicity, race)
- Local geographic population demographics and trends derived from publicly available sources (Group Needs Assessment)

- Network Assessment
- Applicable national demographics and trends derived from publicly available sources
- Health status measures such as those measured by HEDIS as available comparison with selected measures such as those in Healthy People 2010 Measures available through national testing programs such as the National Health and Nutrition Examination Survey (NHANES)

Section 16.
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' 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 [Illinois] 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[1]. 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[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 QI .

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 PHI is included at the end of this section.

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[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

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 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 thirty (30) days and should also be reported to Molina Healthcare within thirty (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.

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Member Name:_____ Member ID #:_____

Member Address:_____ Date of Birth:_____

City/State/Zip:_____ Telephone #:_____

I hereby authorize the use or disclosure of my protected health information as described below.

1. Name of persons/organizations authorized to make the requested use or disclosure of protected health information:

_____
_____
_____

2. Name of persons/organizations authorized to receive the protected health information:

_____
_____
_____

3. Specific description of protected health information that may be used/disclosed:

_____
_____
_____

4. The protected health information will be used/disclosed for the following purpose(s):

_____
_____
_____

5. The person/organization authorized to use/disclose the protected health information will receive compensation for doing so. Yes____ No____

6. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under numbers 7 and 8 on this form.

7. Molina Healthcare may condition the provision of research related treatment on my provision of an authorization for the use or disclosure of PHI for such research.
8. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, Molina Healthcare reserves the right to deny that health care.

9. I understand that I have a right to receive a copy of this authorization, if requested by me.

10. I understand that I may revoke this authorization at any time by notifying Molina Healthcare in writing, except to the extent that:
    a) action has been taken in reliance on this authorization; or
    b) if this authorization is obtained as a condition of obtaining health care coverage, other law provides the health plan with the right to contest a claim under the benefits or coverage under the plan.

11. I understand that the information I authorize a person or entity to receive may be no longer protected by federal law and regulations.

13. This authorization expires on the following date or event* : _____
    **If no expiration date or event is specified above, this authorization will expire 12 months from the date signed below*.

Signature of Member or Member's Personal Representative	Date
Printed Name of Member or Member's Personal Representative, if applicable	Relationship to Member or Personal Representative's Authority to act for the Member, if applicable

A copy of this signed form will be provided to the Member, if the authorization was sought by Molina Healthcare

Section 17.

Glossary of Terms

Action – The denial or limited Authorization of a requested service, including the type, level or provider of service; reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment of a service; or failure to provide services or act in a timely manner as required by law or contract.

Acute Inpatient Care – Care provided to persons sufficiently ill or disabled requiring:

- Constant availability of medical supervision by attending provider or other medical staff
- Constant availability of licensed nursing personnel
- Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to ensure proper medical management by the provider

Ambulatory Care – Health services provided on an outpatient basis. While many inpatients may be ambulatory, the term ambulatory care usually implies that the patient has come to a location other than their home to receive services and has departed the same day. Examples include chemotherapy and physical therapy.

Ambulatory Surgical Facility – A facility licensed by the state where it is located, equipped and operated mainly to provide for surgeries and obstetrical deliveries, and allows patients to leave the facility the same day surgery or delivery occurs.

Ancillary Services – Health services ordered by a provider, including but not limited to laboratory services, radiology services, and physical therapy.

Appeal – A written request by a member or member's personal representative received at Molina Healthcare for review of an action.

Authorization – Approval obtained by providers from Molina Healthcare for designated service before the service is rendered. Used interchangeably with preauthorization or prior Authorization.

Average Length of Stay (ALOS) – Measure of hospital utilization calculated by dividing total patient days incurred by the number of admissions/discharges during the period.

Capitation – A prospective payment based on a certain rate per person paid on a monthly basis for a specific range of health care service.

Centers for Medicare & Medicaid Services (CMS) – A federal agency within the U.S. Department of Health and Human Services. CMS administers Medicare, Medicaid, and SCHIP programs.

Claim – A request for payment for the provision of Covered Services prepared on a CMS-1500 form, UB-04, or successor, submitted electronically or by mail.

Coordination of Benefits (COB) – Applies when a person is covered under more than one group medical plan. The plans coordinate with each other to avoid duplicate payments for the same medical services.

Complaint – Any written or oral expression of dissatisfaction.

Covered Services – Medically necessary services included in the state contract. Covered services change periodically as mandated by federal or state legislation.

Credentialing – The verification of applicable licenses, certifications, and experience to assure that provider status be extended only to professional, competent providers who continually meet the qualifications, standards, and requirements established by Molina Healthcare.

Current Procedural Terminology (CPT) Codes – American Medical Association (AMA) approved standard coding for billing of procedural services performed.

Delivery System – The mechanism by which health care is delivered to a patient. Examples include, but are not limited to, hospitals, providers' offices and home health care.

Denied Claims Review – The process for providers to request a review of a denied claim.

Discharge Planning – Process of screening eligible candidates for continuing care following treatment in an acute care facility, and assisting in planning, scheduling and arranging for that care.

Durable Medical Equipment (DME) – Equipment used repeatedly or used primarily and customarily for medical purposes rather than convenience or comfort. It also is equipment that is appropriate for use in the home and prescribed by a provider.

Dual Coverage – When a member is enrolled with two Molina Healthcare plans at the same time.

Electronic Data Interchange (EDI) – The electronic exchange of information between two or more organizations.

Early Periodic Screening Diagnosis and Treatment Program (EPSDT) – A package of services in a preventive (well child) exam covered by Medicaid as defined in the SSA section 1905 (R). Services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and anticipatory guidance, and screenings for: vision, dental, substance abuse, mental health and hearing, as well as any medically necessary services found during the EPSDT exam.

Emergency Care – The provision of medically necessary services required for the immediate attention to evaluate or stabilize a Medical Emergency (See definition below).

Encounter Data – Molina Healthcare shall collect, and submit to HFS, enrollee service level encounter data for all covered services.

Excluded Providers – Excluded provider means an individual provider, or an entity with an officer, director, agent, manager or individual who owns or has a controlling interest in the entity who has been: convicted of crimes as specified in section 1128 of the SSA, excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of section 1128, or has a contractual relationship with an entity convicted of a crime specified in section 1128.

Expedited Appeal – An oral or written request by a member or member's personal representative received by Molina Healthcare requesting an expedited reconsideration of an action when taking the time for a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function; or would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

Expedited Grievance – A grievance where delay in resolution would jeopardize the member's life or materially jeopardize the member's health.

Federally Qualified Health Center (FQHC) – A facility which:

- receive a grant under Section 329, 330 or 340 of the Public Health Service Act; or

- based on the recommendation of the Health Resources and Services Administration within the Public Health Service, are determined to meet the requirements for receiving such a grant.

Fee-For-Service (FFS) – FFS is a term Molina Healthcare uses to describe a method of reimbursement based upon billing for a specific number of units of services rendered to a member.

Grievance – An oral or written expression of dissatisfaction by a member, or representative on behalf of a member, about any matter other than an action received at Molina Healthcare.

Health Plan Effectiveness Data and Information Set (HEDIS) – Set of standardized measures developed by NCQA. Originally HEDIS was designed to address private employers' needs as purchasers of health care. It has since been adapted for use by public purchasers, regulators and consumers. HEDIS is used for quality improvement activities, health management systems, provider profiling efforts, an element of NCQA accreditation, and as a basis of consumer report cards for managed care organizations.

HFS- Illinois Department of Health and Family Services

HIPAA – Health Insurance Portability and Accountability Act

Illinois Client Enrollment Services (ICES)—the entity contracted by HFS to administer the day-to-day operation of the ICES for clients living in counties in which an MCO is operation.

Independent Practice Association (IPA) – A legal entity, the members of which are independent providers who contract with the IPA for the purpose of having the IPA contract with one or more health plans.

Independent Review Organization (IRO) – A review process by a state-contracted independent third party.

Medicaid – The state and federally funded medical program created under Title XIX of the SSA.

Medical Emergency – Circumstances which a reasonably prudent person would regard as the unexpected onset of sudden or acute illness or injury requiring immediate medical care such that the member's life or health would have been jeopardized had the care been delayed.

Medical Records – A confidential document containing written documentation related to the provision of physical, social and mental health services to a member.

Medically Necessary –a service, supply or medicine is appropriate and meets the standards of good medical practice in the medical community for the diagnosis or treatment of a covered illness or injury, the prevention of future disease, to assist in the Enrollee's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth, as determined by the provider in accordance with Molina Healthcare's guidelines, policies and/or procedures.

Medicare – The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the SSA. Medicare has two parts:

- Part A covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.

- Part B is the supplementary medical insurance benefit (SMIB) covering the Medicare provider's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

Member – A current or previous member of Molina Healthcare.

NCQA – National Committee for Quality Assurance

Participating Provider – A provider that has a written agreement with Molina Healthcare to provide services to members under the terms of their agreement.

Provider Group – A partnership, association, corporation, or other group of providers.

Physician Incentive Plan – Any compensation arrangement between a health plan and a provider or provider group that may directly or indirectly have the effect of reducing or limiting services to members under the terms of the agreement.

Preventive Care – Health care emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination and immunization.

Primary Care Provider (PCP) – A participating provider responsible for supervising, coordinating, and providing primary health care to members, initiating referrals for specialist care, and maintaining the continuity of member care. PCPs include, but are not limited to; Pediatricians, Family Practice Providers, General Medicine Providers, Internists, Obstetrician/Gynecologists, Physician Assistants (under the supervision of a Physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by Molina Healthcare.

Quality Improvement Program (QIP) – A formal set of activities provided to assure the quality of clinical and non-clinical services. QIP includes quality assessment and corrective actions taken to remedy any deficiencies identified through the assessment process.

Remittance Advice (RA) – Written explanation of processed claims.

Referral – The practice of sending a patient to another provider for services or consultation which the referring provider is not prepared or qualified to provide.

Rural Health Clinic (RHC) – a provider that has been designed by the Public Health Service, the US Department of Health and Human Services, or the Governor of the State of Illinois, and approved by the Public Health Service, in accordance with the Rural Health Clinics Act (Public Law 95-210) as a RHC

Service Area – A geographic area serviced by Molina Healthcare, designated and approved by HFS.

Specialist – Any licensed provider, who practices in a specialty field such as Cardiology, Dermatology, Oncology, Ophthalmology, Radiology, etc.

State Children's Health Insurance Plan (SCHIP) – A federal/state funded health insurance program authorized by Title XXI of the SSA and administered by HFS.

Supplemental Security Income (SSI) – A federal cash program for aged, blind, or disabled persons, administered by the SSA.

Sub-Contract – A written agreement between a health plan and a participating provider, or between a participating provider and another sub-contractor, to perform all or a portion of the duties and obligations a plan is required to perform pursuant to the agreement.

Tertiary Care – Care requiring high-level intensive, diagnostic and treatment capabilities for adults and/or children, typically administered at highly specialized medical centers.

Third Party Liability (TPL) – A company or entity other than Molina Healthcare liable for payment of health care services rendered to members. Molina Healthcare will pay claims for covered benefits and pursue a refund from the third party when liability is determined.

Title V – The portion of the federal SSA that authorizes grants to states for the care of CSHCN.

Title XIX – The portion of the federal SSA that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

Title XXI – The portion of the federal SSA that authorizes grants to states for SCHIP.

Utilization Management (UM) – The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as providing assistance to a clinician or patient in cooperation with other parties, to ensure appropriate use of resources. UM includes prior Authorization, concurrent review, retrospective review, discharge planning and case management.

Appendix B

Molina Healthcare Forms

- The following Molina Healthcare forms have been included for your use. Please feel free to make copies as needed.