Dear Provider:

I would like to extend a personal welcome to Molina Healthcare of Illinois (Molina). Enclosed is your Molina Provider Manual, written specifically to address the requirements of delivering healthcare 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. Please use this manual as your guide for all your Medicaid Managed Care business needs. As you review your internal procedures to ensure you meet the required standards, please know the Molina team is here to assist you.

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

Please note, that the managed care system in Illinois has expanded to include all counties across the state. The new program is called HealthChoice Illinois. Members who were formerly enrolled in Family Health Plan (FHP) or Integrated Care Plan (ICP) are covered under HealthChoice Illinois beginning January 1, 2018. Children who are part of the Medically Fragile / Technology Dependent Waiver will be part of HealthChoice Illinois beginning July 1, 2018.

HealthChoice Illinois also covers Medicaid Long Term Services and Supports (MLTSS) enrollees who qualify for Medicaid and Medicare, but who are not part of the Medicare-Medicaid Alignment Initiative (MMAI).

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

Sincerely,

Pamela Sanborn
Plan President
Molina Healthcare of Illinois
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## Section 1 - Molina Healthcare of Illinois Contact Information

### Member Services
<table>
<thead>
<tr>
<th>Address: Molina Healthcare of Illinois</th>
<th>Medicaid Provider Manual - 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>1520 Kensington Rd., Suite 212</td>
<td></td>
</tr>
<tr>
<td>Oak Brook, IL 60523</td>
<td></td>
</tr>
<tr>
<td>HealthChoice Illinois</td>
<td></td>
</tr>
<tr>
<td>Phone: (855) 687-7861</td>
<td></td>
</tr>
<tr>
<td>TTY: 711</td>
<td></td>
</tr>
<tr>
<td>Molina Member Services handles telephone and written inquiries regarding claims, benefits, eligibility/identification, selecting or changing primary care providers, and Member complaints. Representatives are available 8 a.m. to 5 p.m., CST/CDT Monday to Friday, excluding state holidays.</td>
<td></td>
</tr>
</tbody>
</table>

### Claims Department
<table>
<thead>
<tr>
<th>Address: Molina Healthcare of Illinois</th>
<th>Medicaid Provider Manual - 2018</th>
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</thead>
<tbody>
<tr>
<td>PO Box 540</td>
<td></td>
</tr>
<tr>
<td>Long Beach, CA 90801</td>
<td></td>
</tr>
<tr>
<td>Phone: (855) 866-5462 Medicaid providers press 1</td>
<td></td>
</tr>
<tr>
<td>Providers who qualify for hard-copy submissions, please confirm status with your Provider Network Manager. Electronically filed claims must use <strong>Payer ID number 20934</strong>. To verify the status of your claims, please call Provider Network Management. Hard copy (CMS-1500, UB-04) claims must be submitted by mail to the address listed above.</td>
<td></td>
</tr>
</tbody>
</table>

### Contracting Department – Provider Network Management (All Provider Types)
<table>
<thead>
<tr>
<th>Address: Molina Healthcare of Illinois</th>
<th>Medicaid Provider Manual - 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>1520 Kensington Road Suite 212</td>
<td></td>
</tr>
<tr>
<td>Oak Brook, IL 60523</td>
<td></td>
</tr>
<tr>
<td>Phone: (630) 203-3900 Ext. 163965</td>
<td></td>
</tr>
<tr>
<td>Fax: (844) 488-7054</td>
<td></td>
</tr>
<tr>
<td>E-Mail: <a href="mailto:IllinoisProviders@MolinaHealthcare.com">IllinoisProviders@MolinaHealthcare.com</a></td>
<td></td>
</tr>
<tr>
<td>Molina contracts with all provider types for Medicaid, utilizing contractual terms and conditions as outlined by Illinois Department of Healthcare and Family Services (HFS).</td>
<td></td>
</tr>
</tbody>
</table>

### 24-Hour Nurse Advice Line
| Phone: (888) 275-8750 English         | Medicaid Provider Manual - 2018 |
| (866) 648-3537 Spanish                |                               |
| TTY: (866) 735-2929 (English)         |                               |
| (866) 833-4703 (Spanish)              |                               |
| Registered nurses are available 24 hours a day, seven days a week to help Members |   |

### Utilization Management
<table>
<thead>
<tr>
<th>Address: Molina Healthcare of Illinois</th>
<th>Medicaid Provider Manual - 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>1520 Kensington Rd., Suite 212</td>
<td></td>
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<tr>
<td>Oak Brook, IL 60523</td>
<td></td>
</tr>
<tr>
<td>Phone: (855) 866-5462</td>
<td></td>
</tr>
<tr>
<td>Fax: (866) 617-4971</td>
<td></td>
</tr>
<tr>
<td>The Utilization Management (UM) Department conducts concurrent review on inpatient cases and processes Prior Authorization requests.</td>
<td></td>
</tr>
</tbody>
</table>
### Case Management

Address: Molina Healthcare of Illinois  
1520 Kensington Rd., Suite 212  
Oak Brook, IL 60523  
Phone: (888) 858-2156  
Fax: (855) 556-2073

### Quality Improvement

Address: Molina Healthcare of Illinois  
1520 Kensington Rd., Suite 212  
Oak Brook, IL 60523  
Phone: (855) 866-5462  
Fax: (855) 556-2074  
The Quality Improvement Department works with Members and practitioners/providers in administering the Molina Quality Improvement Program (QIP).

### Behavioral Health

Address: Molina Healthcare of Illinois  
1520 Kensington Rd., Suite 212  
Oak Brook, IL 60523  
Phone: (855) 866-5462  
Fax: (855) 556-2073  
24 hours per day, 365 day per year:  
(888) 275-8750 English  
(866) 648-3537 Spanish

### Provider Network Management (Provider Services)

Address: Molina Healthcare of Illinois  
1520 Kensington Rd., Suite 212  
Oak Brook, IL 60523  
Phone: (855) 866-5462  
Email: IllinoisProviders@MolinaHealthcare.com  
Provider Network Management handles telephone and written inquiries from providers regarding address and Tax-ID changes, provider denied claims review, contracting, and training.

### Pharmacy Department

Fax: (855) 365-8112  
Phone: (855) 866-5462  
Email: www.MolinaHealthcare.com  
Pharmacy services are covered according to the Molina Drug Formulary. The formulary and a list of in-network pharmacies are available online at www.MolinaHealthcare.com. Prior Authorization requests for drugs not listed on the Molina Drug Formulary can be faxed. Providers may also call the Molina Pharmacy Department to submit their requests.

### Avesis (Molina’s dental vendor)

Phone: (866) 857-8124  
Email: www.Avesis.com

### MARCH Vision (Molina’s vision vendor)

Phone: (844) 456-2724  
Email: www.MarchVisionCare.com

### Secure Transportation (Molina’s non-emergency transportation vendor)

Phone: (844) 644-6354  
Email: www.SecureTransportation.com  
Members must call at least 72 hours in advance of their appointments to schedule transportation.
Section 2 - Molina Medicaid Programs

(2.1) NEW: HealthChoice Illinois

HealthChoice Illinois is the state’s Medicaid managed care program that serves the estimated 2.7 million Illinois residents who are enrolled onto Medicaid. The mandatory program provides health care coverage for Medicaid enrollees previously under the Family Health Plan (FHP) and Integrated Care Plan (ICP) programs.

The program serves Medicaid clients who have full benefits. This includes children 0-19 years old (All Kids), parents or guardians of children 18 years old or younger (Family Care), pregnant women and newborns (Moms & Babies), and adults ages 19-64 newly eligible for Medicaid through the Affordable Care Act.

Enrollees previously covered under Illinois Health Connect and Medicaid Fee-For-Service are part of managed care under HealthChoice Illinois. HealthChoice Illinois also covers Medicaid Long Term Services and Supports (MLTSS) enrollees who qualify for Medicaid and Medicare, but who are not part of the Medicare-Medicaid Alignment Initiative.

HealthChoice Illinois began serving Medicaid enrollees on January 1, 2018 in existing Medicaid regions. Beginning April 1, 2018 Health Choice Illinois will expand to counties previously operating under the Medicaid Fee-For-Service model.

(2.2) Excluded Populations

Excluded populations from managed care under the FHP program include individuals who meet the following criteria:

Have Comprehensive Third Party Liability insurance

- Qualify for Medicare
- HFS Spenddown
- Presumptive eligibility programs
- Limited eligibility programs
- Department of Children and Family Services (DCFS) foster children
- Children whose care is coordinated by the Division of Specialized Care for Children

The following populations may voluntarily enroll in FHP:

- American Indians or Native Alaskans
- Children younger than 19 years old who get Supplemental Security Income (SSI)
- Children younger than 19 years old who are eligible for Medicaid programs through Article III of the Public Aid Code (305 ILCS 5/3-1 et seq.)

(2.3) Medically Fragile / Technology Dependent Waiver

Beginning July 1, 2018, HealthChoice Illinois will also include children who are enrolled in the Medically Fragile/Technology Dependent (MFTD) waiver program. The program provides home and community-based services to assist Medicaid beneficiaries to live in the community. The program is for individuals younger than 21 years of age who meet criteria for medically fragile and technology dependent.
Section 3 – New: HealthChoice Illinois Managed Long Term Services and Support (MLTSS)

(3.1) - MLTSS Overview

MLTSS includes both Long-Term Care (LTC) and Home and Community Based Services (HCBS). Long-Term Care is for an individual living in a facility-based care setting (such as a nursing home or intermediate care facility). Home and community-based services provide supportive services in the community so that individuals can continue to live in their home and empower them to take an active role in their health care. These programs serve individuals who are older adults, people with intellectual and/or developmental disabilities, or people with physical disabilities.

Medicare remains the primary payer of Medicare-covered services for MLTSS enrollees. Crossover claims and other federally approved Medicaid services not covered by Medicare are not covered MLTSS Services and will be billed to Fee-for-Service. Under the MLTSS program, Molina is responsible for MLTSS services, transportation and some behavioral health services. Under this program, providers will bill Medicare for hospital, doctor, home health, lab test, ambulance, prescriptions drugs, and durable medical equipment.

Molina understands the importance of working with our providers and Community Based Organizations (CBO’s) in your area to ensure our Members receive long-term services and supports that maintain their independence and ability to be served in the most appropriate setting of their choice, whether in their home or in a nursing facility.

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

(3.2) - MLTSS Services and Molina Healthcare

Molina offers services to Members of the following waiver programs:

- Persons who are Elderly
- Persons with Disabilities
- Persons with HIV/AIDS
- Persons with Brain Injury
- Supportive Living Facility
- Medically Fragile Technology Dependent

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

(3.3) - MLTSS Benefits and Approved Services

Adult Day Service - Provides direct care and supervision of adults aged 60 and older in a community-based setting for the purpose of providing personal attention; and promoting social, physical and emotional well-being in a structured setting.

Adult Day Health Transportation - Provides transportation from a Member’s home to the Adult Day Health facility. Does not include transportation to any other service
Day Habilitation - Day habilitation assists with the acquisition, retention, or improvement in self-help, socialization, and adaptive skills which takes place in a non-residential setting, separate from the home or facility which the Member resides. The focus is to enable the Member to attain or maintain his or her maximum functional level. Day habilitation shall be coordinated with any physical, occupational, or speech therapies. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

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

NOTE - Medically Fragile Technology Dependent - Additional services include vehicle modifications, wheelchair lifts and tie down.

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

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

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

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

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

Specialized Medical Equipment and Supplies - Specialized medical equipment and supplies includes devices, items, and appliances that enables the Member to perform activities of daily living (ADL). Limit – Items over $500.00 will require three competitive bids.

Supported Employment - Provides supported employment services that consist of intensive, ongoing supports that enable Members, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. It may include assisting the Member to locate a job or develop a job on behalf of the Member, and is conducted in a variety of settings; including work sites where persons without disabilities are employed.
**Personal Care Services (Individual Provider)** - This is a self-directed service. This service is reimbursed by IHFS. Individual Providers provide assistance with eating, bathing, personal hygiene, and other activities of daily living. This service may also include such housekeeping chores as bed making, dusting, vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the consumer, rather than the Member's family.

**Home Health Aide** - Provides services by an individual that meets IL licensure standards for a Certified Nursing Assistant. Services provided are in addition to any services provided through the State Plan. The amount, duration, and scope of services are based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON.

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

**Therapies** - Service provided by a licensed therapist that meets Illinois standards. Services are in addition to any Medicaid State Plan services for which the Member may qualify. Therapies through the Waiver focuses on long term habilitative needs rather than short-term acute restorative needs.

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

**Placement Maintenance Counseling** - This service provides short-term, issue-specific family or individual counseling for the purpose of maintaining the Member in the home placement. This service is prescribed by a Physician based upon his or her judgment that it is necessary to maintain the child in the home placement.

**Medically Supervised Day Care** - This service offers the necessary technological support and nursing care provided in a licensed medical day care setting as a developmentally appropriate adjunct to full time care in the home. Medically supervised day care serves to normalize the child's environment and provide an opportunity for interaction with other children who have similar medical needs.

**Nurse Training** - This service provides child specific training for nurses, under an approved nursing agency, in the use of new or unique prescribed equipment, or special care needs of the child. This may include training in the use of medical equipment, medicate treatment and CPR.

**Family Training** - Family training includes instruction on treatment regimens and the use of equipment, these services must be included in the Member's care plan. This benefit defines a family as the persons who live with or provide care to the Member, and may include a parent, spouse, siblings, relatives, foster family, in-laws or person designated by the family to be a back-up caregiver.

**Assisted Living (Supportive Living)** - The Supportive Living Program serves as an alternative to Nursing Facility (NF) placement, providing an option for seniors 65 years of age or older and persons with physical disabilities between 22 and 64 years of age who require assistance with activities of daily living, but not the full medical model available through a nursing facility. Members reside in their own private apartment with kitchen or kitchenette, private bath, individual heating and cooling system and lockable entrance.
Behavioral Health Services (M.A and PH.D) - Remedial therapies to decrease maladaptive behaviors and/or to enhance the cognitive functioning of the Member to increase their capacity for independent living.

(3.4) - MLTSS Services by Waiver Program

<table>
<thead>
<tr>
<th>Benefit</th>
<th>*Persons who are Elderly</th>
<th>*Persons with Disabilities</th>
<th>*Persons with HIV/AIDS</th>
<th>*Persons with Brain Injury</th>
<th>*Supportive Living Facility</th>
<th>Children Medically Fragile Technology Dependent (MFTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Day Health (ADH)</td>
<td>X</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Adult Day Health (ADH) Transportation</td>
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<td>Assisted Living (Supportive Living)</td>
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<td>Home Delivered Meals</td>
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<td>Medically Supervised Day Care</td>
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<tr>
<td>Nurse Training</td>
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<td>Nursing Facility</td>
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<td>Personal Emergency Response System (PERS)</td>
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<td>Placement Maintenance Counseling</td>
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<td>Prevocational Services</td>
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<td>X</td>
</tr>
</tbody>
</table>
Respite | X | X | X | X
---|---|---|---|---
Skilled Nursing Services LPN | X | X | X | X
Skilled Nursing Services RN | X | X | X | X
Specialized Medical Equipment and Supplies | X | X | X | X
Supported Employment | | | | X
Therapies | X | X | X | X

*HealthChoice Illinois Members, who are not part of MLTSS, may also qualify for waiver benefits.

(3.5) - Getting Care, Getting Started

All MLTSS Members will receive care management and be assigned Care Coordinator from the Molina Plan. The care management team for MLTSS will include at a minimum the Member and/or their authorized representative, Care Coordinator, and PCP.

Molina’s care coordinator will engage with Members and routinely assess for barriers and opportunities to coordinate medical, behavioral health, and LTSS services in a person-centered manner. Specifically, along with developing the fully integrated Individualized Plan of Care (IPoC), care coordinator will provide verbal, written and/or alternate format information to the Member on:

- After-hours assistance for urgent situations
- Access to timely appointments
- Accommodations available to meet individual linguistic, literacy, and preferred modes of communication
- Advocacy, engagement of family members and informal supports
- Participates in an Interdisciplinary Care Team (ICT)

At a minimum, the care coordinator name and their contact information and hours of availability are included in the care plan, which is shared with all Interdisciplinary Care Team (ICT) participants based on a Member’s recorded preferences. All care coordinators are required to keep email and voicemail current with availability or backup as necessary for Members and their providers. Molina will ensure the provision of the following service coordination services for the Members:

- MLTSS Service Coordination
- Care and Service Plan Review
- Crisis Intervention
- Event Based Visits
- Institution-based Visits
- Medicaid Resolution
- Assessment of LTSS Need
- Health Education
- Assessment of Members clinical risks and needs
- Medication Management
- Coordinate services with the services the Member receives from community and social support providers
- Coordinate services provided between settings of care
Molina will work closely with the various Community Based Organizations (CBO’s) for home and community based services (HCBS) to ensure that the Member is getting the care that they need.

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

Molina Care management team will support the Interdisciplinary Care Team (ICT) for all Members identified as high-risk (Level 3), Dual-Eligible Adult Members, and Members who receive Covered Services under an HCBS Waiver. The ICT will ensure the integration of the Member’s medical and Behavioral Health services, and, if appropriate, Service Package II services. Duties of the ICT are separate from utilization management duties.

Each ICT will be person-centered, built on each Member’s specific preferences and needs, and deliver services with transparency, individualization, respect, linguistic and Cultural Competence, and dignity. Each ICT shall consist of clinical and nonclinical staff whose skills and professional experience will complement and support one another in the oversight of each Member’s needs.

The person centered Integrated Care Team (ICT) will include at minimum the Member and/or their authorized representative, Care Coordinator and anyone a Member requests to participate. ICT Members may also include LTSS providers (e.g. Services Facilitator, Adult Day Health Care Center staff assistive technology, transition coordinator, Nursing Facility staff, etc.), PCP, specialist(s), behavioral health clinician, Targeted Case Management service providers, and pharmacist. The ICT can also include family/caregivers, peer supports, or other informal supports and is not limited to the list of required Members.

(3.6) - INDIVIDUALIZED PLANS OF CARE (IPoC) AND SERVICE PLANS

MLTSS services to be covered by Molina will require coordination and approval.

The Individualized Plan of Care (IPoC) includes the consideration of medical, behavioral, and long-term care needs of the Member identified through a person-centered assessment process. The IPoC must be developed within ninety (90) days after enrollment. The IPoC includes informal care, such as family and community supports. Molina will ensure that a person centered service plan is implemented for the Member in compliance with the Department of Health and Human Services HCBS final rule section 441.301.

A Person Centered Service Plan means the plan that documents the amount, duration, and scope of the home and community based services. The service plan is person centered and must reflect the services and supports that are important for the Member to meet their needs, goals and preferences that are identified through an assessment of functional need. The service plan will also identify what is important with regard to the delivery of these services and supports (42 CFR 441.301), the service plan will be developed within fifteen (15) days after the Member is determined eligible for HCBS Waiver services. The Individualized Plan of Care (IPoC) will be developed under the Member’s direction and implemented by assigned members of the Interdisciplinary Care Team (ICT) no later than the end date of any existing SA or within the state specific timeframes for initial and reassessments. This applies to (state the different waiver populations in which this applies). All services and changes to services must be documented in the IPoC and be under the direction of the Member in conjunction with the case manager.

The ICT) under Member’s direction, is responsible for developing the IPoC, and is driven by and customizable according to the needs and preferences of the Member. As a provider you may be asked to be a part of the ICT.
Additional services can be requested through the Member’s care coordinator anytime including during the assessment process and through the ICT process. Additional service need must be at the Member’s direction and can be brought forward by the Member, the care manager, and/or the ICT team as necessary. Once an additional need is established, the care plan will be updated with the Member’s consent and additional services approved. For additional information regarding MLTSS service coordination and approvals in the Member’s IPoC, please contact Molina at (855) 866-5462.

(3.7) - Transition of Care Programs

Molina has goals, processes and systems in place to ensure smooth transitions between Member’s setting of care and level of care. This includes transitions to and from inpatient settings (i.e. Nursing Facility to Home).

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

(3.8) - Continuity of Care (COC) Policy and Requirements

Molina will allow for the safe transition of Members while adhering to minimal service disruption. In order to minimize service disruption, Molina will honor the Member’s existing service plans, level of care, and providers (including out-of-network providers) for ninety (90) days.

Ongoing provider support and technical assistance will be provided especially to community behavioral health, LTSS providers, and out of network providers during the continuity of care period. All existing Individualized Plan of Cares (IPoCs) and Service Authorizations (SAs) will be honored during the transition period of ninety (90) days.

A Member’s existing provider may be changed during the ninety (90) day transition period only in the following circumstances: (1) the Member requests a change; (2) the provider chooses to discontinue providing services to a Member as currently allowed by Medicaid; (3) Molina or Illinois Healthcare and Family Services identify provider performance issues that affect a Member’s health or welfare; or (4) the provider is excluded under state or federal exclusion requirements.

Out-of-network providers who are providing services to Members during the initial continuity of care period shall be contacted to provide them with information on becoming credentialed, in-network providers. If the provider chooses not to join the network, or the Member does not select a new in-network provider by the end of the Molina will work with the Member in selecting an in-network provider.

Members in a Nursing Facility (NF) at the time of Molina MLTSS enrollment may remain in that NF as long as the Member continues to meet nursing facility level of care, unless they or their families or authorized representative prefer to move to a different NF or return to the community. The only reasons for which Molina may require a change in NF is if (1) Molina or Illinois Healthcare and Family Services identify provider performance issues that affect a Member’s health or welfare; or (2) the provider is excluded under state or federal exclusion requirements.

Reassessments will be completed as necessary and IPoCs updated, Molina will review IPoCs of high-risk (Level 3) Members at least every thirty (30) days, and of moderate-risk (Level 2) Members at least every ninety (90) days, and conduct reassessments as necessary based upon such reviews. At a minimum a health-risk reassessment will be conducted annually for each Member who has an IPoC. In addition, a face-to-face health-risk reassessment will be conducted for Members receiving HCBS Waiver services or residing in NFs each time there is a significant change in the Member’s condition or a Member requests reassessment. The updated
IPoCs will be provided to providers that are involved in providing Covered Services to Members within no more than five (5) Business Days. For additional information regarding continuity of care and transition of MLTSS Members, please contact Molina at (855) 866-5462.

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

Section 4 – Enrollment into Managed Care Programs

(4.1) - Enrollment in Medicaid Programs

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

To apply for HFS medical benefits, individuals, a 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 are followed by a telephone interview. It is also possible to enroll for HFS medical benefits through the DHS website.

DHS can be contacted at:

DHS website:  http://www.dhs.state.il.us/page.aspx
Toll Free at: 1 (800) 843-6154
TTY: 1 (800) 447-6404

Illinois Client Enrollment Services and HFS Health Plan Assignment

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

- Integrated Care Program (ICP) - effective through 12/31/2017
- Family Health Plan (FHP) - effective through 12/31/2017
- Medicare-Medicaid Alignment Initiative (MMAI)
- HealthChoice Illinois Managed Long Term Services and Supports (MLTSS) - effective 1/1/2018
- HealthChoice Illinois - effective 1/1/2018
- Medically Fragile / Technology Dependent Waiver – effective 7/1/2018

Illinois Client Enrollment Services can be contacted at:

ICES website: http://www.enrollhfs.illinois.gov/
Toll Free at: 1 (877) 912-8880:
ICES assists eligible Medicaid enrollees with selecting a health plan of their choice. If enrollees do not choose a plan, ICES will passively assign the enrollee through auto assignment to a plan that services the area where the Member resides.

No eligible Member shall be refused enrollment or re-enrollment, have 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.

(4.2) Effective Date of HFS Eligibility

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

(4.3) Effective Enrollment Date for hospital admissions.

If an enrollee is receiving medical care or treatment as an inpatient in an acute-care hospital on the Effective Enrollment Date, Contractor shall assume responsibility for the management of such care and shall be liable for all claims for Covered Services from that date. For hospital stays that would otherwise be reimbursed under the HFS Medical Program on a per-diem basis, Contractor’s liability shall begin on the Effective Enrollment Date. Notwithstanding the foregoing, for hospital stays that would otherwise be reimbursed under the HFS Medical Program on a DRG basis, Contractor will have no liability for the hospital stay.

(4.4) - Eligibility Verification

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

(4.5) - HFS Eligibility Verification Systems

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

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

(4.6) - Molina Member Eligibility Verification

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

- Molina Member Services at (855) 687-7861
- Molina Web Portal at: https://provider.molinahealthcare.com/provider/login

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

(4.7) - Identification Cards:

Molina Healthcare Sample Member ID card:

Members are reminded in the Member Handbooks to carry ID cards with them when requesting medical or pharmacy services. It is the provider’s responsibility to ensure Molina Members are eligible for benefits and to verify PCP assignment, prior to rendering services. Member ID numbers are the same as the HFS recipient identification number on their HFS medical card.

(4.8) - PCP Dismissal of Member

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

A Member who continues not to comply with a recommended plan of healthcare. Such requests must be submitted at least 60 calendar days prior to the requested effective date.

A Member whose behavior is disruptive, unruly, abusive or uncooperative to the extent that their enrollment with the PCP seriously impairs the PCP’s ability to furnish services to either the Member or other patients. This section does not apply to Members with mental health diagnoses if the Member’s behavior is attributable to the mental illness.

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

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

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

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

(4.10) - PCP Changes

Members may change their PCP designations at any time with the change being effective no later than 31 days following the Member’s request for the change. 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 the first day of the subsequent month.

3. If the Member was assigned to the incorrect PCP due to error by Molina, the Member can retroactively change the PCP, effective the first of the current month.

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

Section 5 - Member Rights and Responsibilities

This section explains the rights and responsibilities of Molina Members as written in the Member Handbook. Illinois law requires that healthcare providers or healthcare facilities recognize Member rights while they are receiving medical care and that Members respect the healthcare provider’s or healthcare facility’s right to expect certain behavior on the part of patients.

(5.1) - Member Rights

- 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 healthcare provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis
- To be able to take part in decisions about your healthcare, 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, its services, its practitioners and providers and Member rights and responsibilities
- To make recommendations about Molina’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

(5.2) - Member Responsibilities:

- For providing to the healthcare 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 healthcare provider
- For reporting to the healthcare 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 healthcare provider or healthcare facility
- For your actions if you refuse treatment or do not follow the healthcare provider's instructions
- For following healthcare 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

(5.3) - 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 6 – HealthChoice Illinois Benefits and Covered Services

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

(6.1) - Co-Payments

There are no Member co-payments associated with covered services provided through Molina’s coverage programs. Some benefits may have limitations. Please call Provider Network Management for addition information or for a complete list of benefits at (888) 858-2156.

(6.2) - Covered Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage and Benefit Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Practice Nurse Services</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Ambulatory Surgical Treatment Center Services</td>
<td>Covered benefit</td>
</tr>
<tr>
<td></td>
<td>Some limitations apply</td>
</tr>
<tr>
<td>Assistive/Augmentative Communication Devices</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Blood, blood components and the administration thereof</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Chiropractic services for enrollees under the age of twenty-one (21)</td>
<td>Covered benefit. Limited to Members 20 years of age and younger for the treatment of spine by manual manipulation.</td>
</tr>
<tr>
<td></td>
<td>Not covered for Members 21 and over.</td>
</tr>
<tr>
<td>*Dental services including oral surgeons (20 years of age or younger)</td>
<td>Covered benefit. Dental services, including oral surgery, X-rays, sealants, fillings, crowns (caps), root canals, dentures and extractions (pulling)</td>
</tr>
<tr>
<td></td>
<td>Cleanings (1 every 6 months)</td>
</tr>
<tr>
<td></td>
<td>Dental exams (1 every 6 months)</td>
</tr>
<tr>
<td></td>
<td>Some limits apply</td>
</tr>
<tr>
<td>Dental services (21 years of age and older)</td>
<td>Covered benefit. Dental services including oral surgery, X-rays, fillings, crowns (caps), root canals, extractions (pulling), dentures and denture repairs.</td>
</tr>
<tr>
<td></td>
<td>Pregnant women can get extra services. The services include exams, cleanings and deep cleanings.</td>
</tr>
<tr>
<td></td>
<td>One cleaning and one dental exam per year as a standard benefit.</td>
</tr>
<tr>
<td></td>
<td>As an additional benefit, Members 21 years of age and older get a second cleanings per year and a second dental exam per year</td>
</tr>
<tr>
<td></td>
<td>Some limitations apply</td>
</tr>
<tr>
<td>Service Description</td>
<td>Covered Benefit</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Emergency dental services</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Diagnostic services</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>Covered benefit. Most limitations apply.</td>
</tr>
<tr>
<td>Emergency services</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for Enrollees under the age of twenty-one (21)</td>
<td>Covered for Members 20 years of age or younger. Excludes shift nurses serving for Members in the Medically Fragile and Technology Dependent (MFTD waiver or Long Term Services and Supports waivers.</td>
</tr>
<tr>
<td>Family Planning Services and supplies</td>
<td>Covered benefits include:</td>
</tr>
<tr>
<td></td>
<td>Yearly exam for females 12 to 55 years of age, which includes a breast exam, pelvic exam and pap smear.</td>
</tr>
<tr>
<td></td>
<td>Pregnancy testing. Contraceptive-related services such as the insertion of intrauterine devices (IUDs) and the implantable contraceptive; permanent methods of birth control, including tubal ligation, trans-cervical sterilization and vasectomy.</td>
</tr>
<tr>
<td></td>
<td>Contraceptive supplies, such as birth control pills, rings, patches and emergency contraception.</td>
</tr>
<tr>
<td>Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and other Encounter rate clinic visits</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Hearing (audiology) services, including hearing aid</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>Covered benefit</td>
</tr>
<tr>
<td></td>
<td>Also includes nursing care for Members 20 years of age and younger who are not in the Medically Fragile and Technology Dependent (MFTD) waiver.</td>
</tr>
<tr>
<td>Hospice care (care for terminally ill)</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Immunizations (shots)</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Inpatient hospital</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Long Term Services and Supports</td>
<td>Determination of need must be completed for individuals eligible for waivers.</td>
</tr>
<tr>
<td>Laboratory and X-ray services</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Medical supplies, equipment, prostheses and orthoses</td>
<td>Covered benefit</td>
</tr>
<tr>
<td></td>
<td>Some limitations apply</td>
</tr>
<tr>
<td>Service Description</td>
<td>Benefit Type</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Mental health and substance abuse services</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Nursing facility services</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Obstetrical (maternity care) and gynecological services</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Practice visits for individuals with developmental disabilities and serious illness.</td>
<td></td>
</tr>
<tr>
<td>Includes office visits for prenatal, postpartum and newborn care, which included breast pumps, hospital and delivery services</td>
<td></td>
</tr>
<tr>
<td>Includes at-risk pregnancy services</td>
<td></td>
</tr>
<tr>
<td>Women may self-refer to Obstetrician (OB) or Obstetrician/Gynecologist (OB/GYN) provider</td>
<td></td>
</tr>
<tr>
<td>Outpatient hospital services</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Some limitations apply</td>
<td></td>
</tr>
<tr>
<td>Optical services and supplies</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Optometrist services</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>*Pharmacy services</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Physical and occupational services</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Podiatry (foot) services</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Post-stabilization services</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>*Prescription drugs, including certain prescribed over-the-counter drugs</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Preventive mammogram (breast) and cervical cancer (pap smear) exams</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Women may self-refer</td>
<td></td>
</tr>
<tr>
<td>Preventive male cancer screenings</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Primary Care Provider (PCP) services</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Renal dialysis (kidney disease) services</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Respiratory Equipment and supplies</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Some limitations apply</td>
<td></td>
</tr>
<tr>
<td>Specialist services</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Speech therapy services</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>Transplants</td>
<td>Covered benefit</td>
</tr>
<tr>
<td>*Transportation to covered services, pharmacy trips and the Women, Infants and Children (WIC) office appointments (Non-Urgent)</td>
<td>Covered benefit</td>
</tr>
</tbody>
</table>
*Vision (optical and optometrist) services, including eyeglasses

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>One exam per year for all Members</td>
<td></td>
</tr>
<tr>
<td>One pair of eyeglasses (lenses and frames) in a two-year period for all Members</td>
<td></td>
</tr>
<tr>
<td>No restrictions on replacement eyeglasses for Members 0 to 20 years of age.</td>
<td></td>
</tr>
<tr>
<td>Members 21 years of age and older are limited to replacement lenses when medically necessary.</td>
<td></td>
</tr>
<tr>
<td>As an additional benefit, Molina provides a $40 credit to use toward eyeglasses benefit (lenses and frames) per year when Members choose outside of the approved options.</td>
<td></td>
</tr>
</tbody>
</table>

Well child exams (EPSDT Services)

- Covered benefit

Yearly well-adult exams

- Covered benefit

*Some or all portions of these services are provided by Molina’s delegated vendors. Please refer to section 21 to learn more. For information on MLTSS services please refer to the MLTSS section in this manual.

(6.3) - In Office Laboratory Tests

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

For more information about In-Network Laboratory Providers, please consult the Molina Provider Directory (https://providersearch.molinahealthcare.com/). For testing available through In-Network Laboratory Providers, or for a list of In-Network Laboratory Provider patient services centers, please reach out to the In-Network Laboratory Provider.

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

(6.4) - Telehealth

Telehealth is the use of a telecommunication system to provide medical services between places of lesser and greater medical capability and/or expertise, for the purpose of evaluation and treatment. Medical data exchanged can take the form of multiple formats: text, graphics, still images, audio and video. The information or data exchanged can occur in real time (synchronous) through interactive video or multimedia collaborative environments or in near real time (asynchronous) through “store and forward” applications. The telecommunication system must, at a minimum, have the capability of allowing the consulting practitioner to examine the patient sufficiently to allow proper diagnosis of the involved body system. The system must also be capable of transmitting clearly audible heart tones and lung sounds, as well as clear video images of the patient and any diagnostic tools, such as radiographs. For additional telehealth information, see 89 Ill. Adm. Code 140.403. Telephones, facsimile machines, text, and other electronic mail systems are not acceptable telecommunication systems.

Telehealth services include telemedicine as well as telepsychiatry. Under the Department’s telehealth policy, eligible providers will be paid as either an originating site or distant site.
(6.5) - Long Term Services and Supports (LTSS)

Certain HealthChoice Illinois Molina Members are eligible for Long Term Services and Supports (LTSS) depending on their 1915c Medicaid Waiver eligibility. The following waivers are included in the HealthChoice Illinois population: elderly, disability, HIV/AIDS, traumatic brain injury and supportive living facility. These services are coordinated through our Medical Management Program. Section 5 - Limited Covered Services:

- Abortion services where necessary to protect the health or life of the pregnant woman, or in cases of rape or incest.
- Health plan may provide sterilization services only as allowed by State and federal law.
- If Health plan provides a hysterectomy, Health plan shall complete HFS Form 1977 and file the completed form in the Enrollee’s medical record.

Section 7 - Non-Covered Services:

(7.1) – Non-Covered Services

Here is a list of some of the medical services and benefits that Molina does not cover:

- Services that are experimental or investigational in nature;
- Services that are provided by a non-Network Provider and not authorized by your Health Plan
- Services that are provided without a required referral or required prior authorization;
- Elective cosmetic surgery
- Infertility care
- Any service that is not medically necessary
- Services provided through local education agencies
- Early Intervention Services, including Care Management
- Services funded through the Juvenile Rehabilitation Services Matching Fund
- Services such as assisted suicide

(7.2) - Critical Incident Reporting and Management

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

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

The following lists of “incidents” are required to be reported in a timely manner:

- Abuse: The infliction (by one’s self or others) of injury, unreasonable confinement, intimidation or cruel punishment with resulting physical harm, pain or mental anguish.
- Physical abuse is the intentional use of physical force resulting in injury, pain or impairment. It includes pushing, hitting, slapping, pinching and other ways of physically harming a person. It can also mean placing you in incorrect positions, force feeding, restraining or giving medication without your knowledge.
- Emotional abuse occurs when a person is threatened, humiliated, intimidated or otherwise psychologically hurt. It includes the violation of your right to make decisions and/or the loss of your privacy.
• Sexual abuse includes rape or other unwanted, nonconsensual sexual contact, but it can also mean forced or coerced nudity, exhibitionism and other non-touching sexual situations, regardless of the age of the perpetrator.

• Neglect: When someone has a duty to do so, but fails to provide goods, services, or treatment necessary to assure your health and welfare.

• Exploitation: the unlawful or improper act of using a Member or a Member’s resources for monetary or personal benefit, profit, or gain.

• Misappropriation: depriving, defrauding or otherwise obtaining the money, or real or personal property (including medication) belonging to you by any means prohibited by law.

(7.3) - Death of a Member

The maximum timeframe for reporting an incident shall be twenty-four (24) hours. The initial report of an incident within twenty-four (24) hours may be submitted verbally, in which case the person/agency/entity making the initial report shall submit a follow-up written report within forty-eight (48) hours.

Molina will report Critical Incidents for each of the following: Nursing Facility Services; HCBS Waiver for Persons who are Elderly; HCBS Waiver for Assisted Living, Supportive Living Program; HCBS Waiver for Persons with Physical Disabilities; HCBS Waiver for Persons with HIV/AIDS; and HCBS Waiver for Persons with Brain Injury.

(7.4) - Claims for LTSS Services

Providers are required to bill Molina for all LTSS waiver services through EDI submission or through the Web Portal. After registering on the Molina Web Portal a provider will be able to check eligibility, claim status and create/submit claims to Molina. To register please visit: Provider Self Services Web Portal

Providers may submit EDI claims using Change Healthcare (CHC), Molina’s EDI Clearinghouse with the IL unique Molina Payer ID of 20934.

(7.5) - Atypical Providers

The Centers for Medicare & Medicaid Services (CMS) defines atypical providers as providers that do not provide health care. Examples of Atypical providers include taxi services, home and vehicle modifications, habilitation and respite services, etc. Although, they are not required to register for an NPI, these providers perform services that are reimbursed by Molina.

Atypical providers are required to use their Medicaid ID (HFS Provider ID), as appropriate for the type of service rendered.

(7.6) - Claims Submission: Web-Portal

We encourage our LTSS providers to utilize the Molina web portal to submit claims. Please see the Web-Portal Quick Reference Guide http://www.molinahealthcare.com/webportal/docs/Providers/UserManual/Quick%20Reference%20Guide.pdf for further details. You may also contact your Provider Network Manager for additional information.

(7.7) - Timely Filing Limit

For an Illinois Medicaid claim to be considered as filed on a timely basis, the complete claim must be submitted within 180 days after the date of service or in the case of a date range from the end date of service.

(7.8) - Member Responsibility
Members residing in a Skilled Nursing Facility, Intermediate Care Facility, Nursing Facility, SLF (Supportive Living Facility), or those receiving in-patient Hospice may have patient liability (cost share). If applicable to the Member, this amount is determined by the state and it is the responsibility of the long-term care facility provider to collect this amount from the Member. This amount can change on a monthly basis. Claims billed by long-term care facilities will have the Member's patient liability amount deducted from claims payments until the patient liability amount is met for that month.

Section 8 - Behavioral Health Services

PCPs can refer Members in need of behavioral health services or Members can self-refer by calling Molina Behavioral Health Department at (888) 858-2156. Molina is available 24 hours a day, seven days a week for behavioral health needs. The services Members receive will be confidential. Some behavioral health services require prior authorization.

Behavioral Health Services Include:
- Inpatient services
- Outpatient hospital services
- Psychiatric doctor services

(8.1) - 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

(8.2) - Out of Area Emergencies

Members having a behavioral health emergency who cannot get to a Molina 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 24-48 hours

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

(8.3) - Screening, Assessment and Support Services (SASS) Program

The Children’s Mental Health Act of 2003, Illinois Public Act 93-0495, requires that all Medicaid eligible children and adolescents potentially requiring psychiatric inpatient hospitalization, acute care or sub-acute (Psychiatric Residential Treatment Facility) are screened for the viability of stabilization in the community prior to admission.

With the passage of the Children’s Mental Health Act of 2003, the Illinois Department of Healthcare and Family Services (HFS) along with the Illinois Department of Human Services (DHS) and Illinois Department of Children and Family Services (DCFS) collaborated to implement the Screening, Assessment and Support Services (SASS) program in July 2004.
The SASS program has a coordinated, single point of entry for children in need of mental health services and provides immediate pre-hospitalization screening, crisis intervention, stabilization services, and support to children and families when a child is hospitalized. Additionally, post-discharge services are provided to ensure continuity of care, including case management, transitional programming and psychiatric treatment as necessary. The SASS program has two components:

- A crisis and referral system known as CARES (Crisis and Referral Entry Services) that operates a toll-free phone line which handles mental health crisis calls for children and youth in Illinois; and
- Geographically dispersed screening agents known as SASS providers.

(8.4) - Mobile Crisis Response Services and the CARES Line

HFS requires Molina to provide mobile crisis response services as part of the covered benefits available to Members younger than 21 years old. Molina has contracted with and will utilize the existing sass providers and referrals from the Carol’s line to deliver mobile crisis response services. All contracted sass providers will be expected to meet the requirements for the mobile crisis response services.

The CARES Line can be reached at (800) 345-9049

(8.5) - Mobile Crisis Response Services

Mobile Crisis Response Services, including a face-to-face screening, must be available every day of the year on a 24 hour basis for all Molina Members who are younger than 21 years old and who are experiencing a behavioral health crisis. Face-to-face crisis screening must be initiated within 90 minutes of notification, or referral for crisis services. The face-to-face screening and assessment disposition must be completed within four hours of the CARES referral. Providers must report response time and care disposition to the Molina care coordination department within 24 hours.

(8.6) - Provider Credentials

Staff responsible for providing Mobile Crisis Response Services must hold one of the following credentials:

- Mental health professional (MHP) with direct access to a Qualified Mental Health Professional
- Qualified Mental Health Professional (QMHP)
- Licensed Practitioner of the Healing Arts (LPHA)

(8.7) - State Approved Screening Tool

Providers responsible for administering Mobile Crisis Response Services must utilize the Childhood Severity of Psychiatric Illness (CSPI), which is the prevailing Illinois decision support tool for all face-to-face mobile crisis screening or any State-defined successor.

Providers must also report on clinical CSPI data. The CSPI summary form must be sent to MHILBehavioralHealthReferrals@MolinaHealthcare.com email address within 24 hours of the completion of the SASS screening. Alternatively the information may be sent to: Fax: (866) 916-3249.

Providers must use the CSPI for each screening of the number throughout the duration of the case.

(8.8) - Community Stabilization

Mobile Crisis Response Service providers, in the event a Member in crisis can be stabilized in the community, must be provided immediate crisis and stabilization services. Crisis and stabilization services are activities performed to stabilize a child in psychiatric crisis to avoid more restrictive levels of treatment that have the goal
of immediate symptom reduction, stabilization and restoration to a previous level of role functioning. Providers must deliver crisis and stabilization services to the child and his/her parent, guardian or caregiver as necessary to resolve the immediate crisis and to stabilize the child’s behavioral and emotional condition. Mobile Crisis Response Services providers must do the following:

- Arrange a follow-up appointment with the child and parent, guardian or caregiver within 48 hours after the initial screening and assessment.
- Develop a preliminary treatment plan for the initial provision of mental health services to the child, parent, guardian or caregiver and ongoing stabilization mental health services. This preliminary plan must be approved and signed by the parent, guardian or caregiver.
- Develop, coordinate, implement, and/or provide outpatient service alternatives when hospitalization does not occur. These services shall include, but not limited to, psychiatric consultation, intensive individual therapy, family therapy, behavioral management, in-home therapeutic services and education.

**8.9 - Crisis Safety Plan Development**

Mobile crisis response services providers must establish crisis safety plans for all Members that present in behavioral health crisis. The crisis safety plan should be unique to the Member and circumstances leading to the crisis situation. The crisis safety plan is an in-community-in-the-moment tool used by the child, parent, guardian or caregiver to reduce or manage worsening symptoms, promote wanted behaviors, prevent or reduce the risk of harm or diffuse dangerous situations. The specifics of the crisis safety plan must be meaningful to an actionable step by the child, parent, guardian or caregiver. Mobile crisis response services providers must do the following for each Member:

- Educate and orient the family to the components of the crisis safety plan, ensure that the plan is reviewed by the family regularly, and detail how the plan is updated as necessary,
- Share the crisis safety plan with all necessary medical professionals, including care coordinators with the permissions established via consent or release,
- Provide the families with physical copies of the crisis safety plans for: Members stabilized in the community, prior to the completion of the crisis screening event, and Members admitted to an inpatient psychiatric hospital, prior to discharge of the number from that facility.

**8.10 - Inpatient Institutional Treatment**

Mobile crisis response services providers must facilitate inpatient admission to an appropriate inpatient institutional treatment setting when a Member cannot be stabilized in the community. Providers responsible for administering mobile crisis response services must inform the Members parents, guardians, caregivers or residential staff about all of the available service providers and pertinent policies needed to allow the involved parties to select an appropriate inpatient institutional treatment setting that is appropriate, as well as participate in the child admission evaluation.

Once a Member has been admitted to an inpatient facility following a SAST screening, Molina providers must be proactive in helping to reduce the hospital stay by providing consultation and advocacy services, including working closely and cooperatively with the hospital team who is directing treatment. Providers must also work with the Members, the Members family and Molina in the following ways:

- Offering supportive services to the child’s parent guardian or caregiver, encourage their participation in treatment planning, visits to the child at the hospital, and participate in discharge planning, and pre-discharge home visits.
- Collaborating with a psychiatric hospital treatment team to ensure appropriate discharge planning,
• Having available staff to attend and participate in all hospital staffing meetings including, but not limited to, the initial 72 hour staff meeting, subsequent staff meetings or the discharge meeting.
• Following up in coordinating with the parent guardian or caregiver to facilitate the child’s return to his or her home.

(8.11) - Care Coordination

Providers responsible for administering mobile crisis response services must be provide care coordination activities from the point of initial screening and continue through treatment planning, service provision, linkage and after care planning. Care coordination must include Molina case managers and implement the wraparound model of care, involving an intensive plan of care and all pertinent providers. The requirements include the following:

• Determine whether there are current mental health providers involved with the child and involve them as soon as possible including substance abuse or other services,
• With the family or other caregivers permission and as clinically indicated, must include other key child serving systems, such as, but not limited to, educational, Chow welfare and medical providers, in the assessment and care coordination process,
• Request permission from the family or other caregiver to contact the other service providers and explain to the family the importance of coordinating the care,

If consent is given contact current providers as necessary to maintain communication with that provider throughout the Direction of the Child’s involvement with mobile crisis response services. Communications should begin early in the process to assist with assessment and continue regarding treatment planning, progress in care and discharge planning.

(8.12) - Report

Within 24 hours of completing a face-to-face crisis screening, providers responsible for administering Mobile Crisis Response Services must provide a report to Molina on the following metrics:

• Response time to the CARES call
• Time frame to initiate a screening post-referral
• Time frame to complete screening post-referral
• All clinical CSPI data
• Screening outcome (Initiated/Completed)
• Served in community
• Hospitalized
• Incomplete Services
• Declined Service
• Outcome not recorded

The report on the above metrics should be submitted to: MHLBehavioralHealthReferrals@MolinaHealthcare.com or Fax: (866) 916-3249.

Section 9 - Prescription Drugs

Prescription drugs are covered through Molina. A Preferred Drug List (PDL) and a list of in-network pharmacies is available online at www.MolinaHealthcare.com or via phone at (888) 858-2156.

Prescription drug therapy is an integral component of your patient’s comprehensive treatment program. The goal of Molina is to provide our Members high quality, cost effective drug therapy.
At Molina, medications can fall into the following categories. Information on procedures to obtain these medications is described in detail within this document and also available on the website.

(9.1) - Formulary Medications
Formulary Medications do not require prior authorization (PA). Molina covers up to a 30-day supply of medication. In some cases, patients may only be able to receive certain quantities of medication. Information on quotas are included and can be found in the Formulary.

(9.2) - Formulary Medications with Prior Authorization
Formulary medications with PA may require the use of first line medications before they are approved. Information on how to complete a PA can be found on the Molina website.

(9.3) - Non-Formulary Medications
Non-Formulary medications may be considered for exception when Formulary medications are not appropriate for a particular patient or have proven ineffective. Requests for Formulary exceptions are completed on the Molina Prior Authorization form. Clinical evidence must be provided and is taken into account when evaluating the request to determine medical necessity.

(9.4) - Medications not covered
Medications not covered by Medicaid are excluded from coverage. For example, drugs used in the treatment of fertility or those used for cosmetic purposes are not part of the benefit. A list of these drug types can be found on the Molina website.

(9.5) - Injectable and Infusion Services
Injectable products and all infusion drug requests require a prior authorization review and are supplied by Molina’s specialty pharmacy vendor. Specialty drugs require a prior authorization review and are not available through the retail pharmacy network. Please refer to the PDL at www.MolinaHealthcare.com. Certain injectable products are also available through the “buy and bill” provision as a medical benefit and some may require prior authorization.

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

(9.6) - Pain Safety Initiative (PSI) Resource
Safe and appropriate opioid prescribing and utilization is a priority for all of us in healthcare. Molina requires providers to adhere to Molina drug formularies and prescription policies designed to prevent abuse or misuse of high-risk chronic pain medication. Providers are expected to offer additional education and support to Members regarding opioid and pain safety as needed.

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

Section 10 - Preventive Services

(10.1) - Adult Well Visits
Adults (age 19 years and older) are eligible for an annual well visit. These comprehensive examinations should be done in accordance with current American Academy of Family Physicians guidelines. Exams should include, but are not limited to the following components: initial and updated health history, height and weight measurement, nutritional assessment and counseling, appropriate risk assessment and lifestyle counseling, health assessment and anticipatory guidance.

Members should be encouraged to schedule this visit with their primary care provider. All Members should have a complete health history and physical examination with their Primary Care Provider (PCP) within the first year of Membership with Molina.

Molina publishes annual preventive health guidelines for adults ages 22-64, pregnant women and Seniors and Persons with Disabilities. These guidelines contain recommended age and gender appropriate services. The guidelines are posted online at www.MolinaHealthcare.com.

(10.2) - Risk Assessment Screenings

Providers should screen and can bill for the following risk assessment screenings for adult women: preconception risk assessment and perinatal depression screening. These screenings should be billed in addition to the appropriate office visit or evaluation and management visit CPT code. Perinatal depression screenings can be performed during prenatal and postnatal appointments.

(10.3) - Adult Immunizations

Molina covers all medically necessary immunizations for adults, including flu vaccines, as recommended by the Centers for Disease Control and Prevention (CDC). Adult Members should receive immunizations, prescribed by the Member’s PCP, according to the latest annual update of the CDC’s Recommended Immunization Schedule for Adults Aged 19 years or Older, United States. For the current CDC adult immunization schedule, visit: http://www.cdc.gov/vaccines/schedules/index.html

(10.4) - Prenatal Care

(10.4.1) - Normal Pregnancy

Molina pregnant Members should receive timely care that is evidence-based. Prenatal care provided as early as possible along with regular ongoing care will optimize outcomes. A comprehensive prenatal evaluation and care should be based on the latest recommendations from the American College of Obstetrics and Gynecology (ACOG), the U.S. Preventive Services Task Force (USPSTF) and other national clinical or specialty organizations. Care provided should include a health history, comprehensive exams, lab tests, ongoing risk assessment, nutritional assessment and counseling, and depression screening. Each Member should have an individualized plan of care that takes into account psychosocial, environmental and health literacy needs. The Handbook for Providers of Healthy Kids Services has multiple resources for providers to use and is located at: https://www.illinois.gov/hfs/SiteCollectionDocuments/hk200.pdf

Women are eligible for all CDC recommended immunizations and a postpartum visit after delivery for a normal pregnancy. Molina publishes annual preventive health guidelines for pregnant women. The guidelines are posted online at http://www.molinahealthcare.com/members/common/en-US/healthy/womwell/maternity/prenatcare/Pages/immunscrnings.aspx

A charge may be submitted for only one six-week postpartum visit per Member, per delivery. Additional visits for postoperative wound checks or outside the six-week postpartum period must be billed with the appropriate evaluation and management CPT Code.
(10.4.2) - High-Risk Pregnancy

A significant number of pregnant women on Medicaid are found to be at risk for complications or conditions that can affect the mother, the baby or both. Molina has a pregnancy management program that strives to improve birth outcomes through early identification and trimester specific interventions appropriate to the risks and needs identified. The program supports and assists physicians in the delivery of care to Members. For more information about the Molina maternity program, including incentives for providers. See Section 11.3 of this provider manual.

(10.5) - Adult Dental Services

In addition to dental services afforded to all HFS clients, HealthChoice Illinois adults have the value added services of an additional exam and additional cleanings per year. Pregnant women are eligible for additional services, such as periodic exams, cleanings and deep cleanings.

Molina provides dental coverage through Avesis. Call (866) 857-8124 to locate a network dentist for Members.

(10.6) - Well Child Visits

Well-child visits as defined in the HFS Healthy Kids Handbook must include: a comprehensive health history, nutritional assessment, height and weight and growth charting, comprehensive unclothed physical examination, laboratory procedures, immunizations, periodic developmental screening using an approved screening tool, periodic objective screening for emotional development using approved screening tool, objective vision and hearing screening, risk assessment, anticipatory guidance, and perinatal depression screening for mother's in the most appropriate clinical setting.

It is recommended that health screenings be provided to children, on a periodicity schedule based on acceptable medical practice standards, such as the schedule recommended by the American Academy of Pediatrics or the American Academy of Family Physicians, or the following schedule provided by HFS. Preventive services are limited to those specified in this periodicity schedule.

- Birth
- During first 2 weeks
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months/30 months
- Three to Six years old: Annually

Six to twenty-one years old: Every other year, at a minimum, or more often if medically-recommended, or if following an acceptable medical practice standard for the periodicity schedule.

Providers should bill using age appropriate CPT codes. Molina providers are eligible for enhanced MCH add-on rates as specified on the HFS fee schedule.

(10.7) - Additional Billable Services During Well Child Visits
Molina providers are eligible for additional reimbursement for the services listed below when billed with appropriate CPT codes as listed in the HFS Healthy Kids Handbook, which can be found online at www.Illinois.gov. These services should be billed in addition to the age appropriate CPT code for well-child visit or office visit. Encounter rate reimbursed providers (e.g.) FQHCs, RHCs and ERCs must detail the services provided on the encounter rate form.

(10.8) - Immunizations

When submitting a claim for the administration of a VFC-acquired vaccine, providers must bill using the CPT code for the specific vaccine product, rather than the vaccine administration service CPT code. However, the charge amount should be the provider's usual and customary charge for the appropriate vaccine administration service CPT code, even if that charge exceeds the regional VFC maximum immunization administration fee.

(10.9) - Objective Risk Assessment

Use CPT code 96160 for administration of patient-focused health risk assessment instrument with scoring and documentation, per standardized instrument. A postpartum depression screening of the mother can be billed during child’s visit using modifier HD. During a well-child health examination, youth who show signs or symptoms of mental or emotional problems, or indicate signs of substance abuse, should be screened using HFS approved screening tools.

(10.10) - Objective Developmental Screening

Performed no less than at priority intervals (e.g., based on the recommended periodicity schedule), with surveillance during all well-child visits in order to identify children with developmental and social emotional delays. For children younger than age three, providers should administer an objective developmental screening using a standardized instrument approved by HFS, according to the AAP guidelines, at 9 months, 18 months and 24/30 months of age. Use CPT Code 96110 or 96111 based on the approved screening tool as listed in HFS Healthy Kids Handbook.

Objective developmental screening specific to Autism should be conducted for all children at the 18-month and 24-month visits.

Use CPT code 96110 or 96111 based on the approved screening tool that is used as listed in HFS Healthy Kids Handbook.

(10.11) - Objective Vision Screening

Use the appropriate CPT code for the vision screening service when a separate objective vision screening, is provided. Beginning at age three, an additional objective vision screen in the primary care setting is recommended annually, using an age appropriate method consistent with AAP guidelines for children between the ages of 3 through 6; and again at ages 8, 10, 12, 15 and 18 years.

(10.12) - Objective Hearing Screening

Use the appropriate CPT code for the objective hearing screening service when a separate objective hearing screening is provided. Objective hearing screening, using standard testing methodology, is recommended annually for children between the ages of 4 through 6, and at 8 and 10 years of age. The timing and number of hearing re- evaluations for children with risk factors should be customized and individualized depending on the relative likelihood of a subsequent delayed-onset hearing loss. Early and more frequent assessment may be indicated. Every infant with confirmed hearing loss should be evaluated by an otolaryngologist with knowledge
of pediatric hearing loss and have at least one examination to assess visual acuity by an ophthalmologist experienced in evaluating infants.

(10.13) - Laboratory procedures

To receive reimbursement for laboratory services, all providers, regardless of type of business or professional licensure, must have a current Clinical Laboratory Improvement Amendments (CLIA) certificate on file with HFS.

(10.14) - Lead Screening

Federal mandates and HFS policy recommend that all children enrolled in Medicaid be considered at risk for lead poisoning and receive a screening blood lead test at 12 and 24 months. Children older than 24 months, up to age 7 years, for whom no record of previous screening blood lead test exists, should also receive a screening blood lead test. All children enrolled in the department's Medical Programs are expected to receive a blood test regardless of where they live. The provider who draws the specimen for the Illinois Department of Public Health to process may bill for obtaining the sample by using the CPT Code 36415 or 36416 with the U1 modifier. Providers enrolled for Category of Service 30 who have the requisite equipment may bill for Clinical Laboratory Improvement Act (CLIA) waived blood lead analysis [ESA Biosciences LeadCare II Blood Lead Testing System (Whole Blood)] using the Current Procedural Terminology (CPT) Code 83655 with the QW modifier.

(10.15) - Childhood Immunization Schedule

Molina Members should receive all recommended childhood vaccines according to the Centers for Disease Control and Prevention (CDC). For the current CDC vaccine schedule, go to http://www.cdc.gov/vaccines/schedules/index.html.

(10.16) - Vaccines For Children (VFC) Program

The Vaccines For Children (VFC) program provides vaccines free of charge for eligible Illinois children ages birth through 18 years old. All VFC eligible HFS enrolled participants should get their vaccines from the Illinois Vaccines for Children Program or the Chicago Vaccines for Children Program.

For updated information regarding the VFC program providers may visit the following HFS link: https://www.illinois.gov/hfs/MedicalProviders/NonInstitutional/Pages/default.aspx

(10.17) - I-CARE Immunization Database

The Illinois Department of Public Health operates an online immunization database called I-CARE that allows providers to register all vaccines provided to children in Illinois regardless of payment source. Molina encourages its network providers to use I-CARE.

I-CARE also serves as the mandatory online ordering platform for VFC immunizations, allow providers to track shipments, monitor inventory, enter daily temperature logs, and run VFC reports.

(10.18) - Interperiodic Screenings

Interperiodic screenings for children may be provided as medically necessary, or when required or mandated for: participation in school; enrollment in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC); admission to day care; placement in a licensed child welfare facility including foster home, group home or institution; attendance at camp; participation in a sports program; enrollment in an early
childhood education program; required by the child's Individual Education Plan (IEP) or Individual Family Service Plan (ISFP), or at the request of the parent or guardian.

(10.19) - BMI Assessments

Providers are encouraged to assess and document BMI percentile at least one time per year for pediatric patients ages 2 through 20. BMI assessment may be done during any visit, sick child or preventive.

Claims for an episode or encounter where BMI is assessed must include the appropriate CPT or UB-04 revenue code, and appropriate diagnosis codes. Documentation must include a note in the patient's record indicating: the date on which the BMI percentile was assessed; one of the following measurements: BMI percentile or BMI percentile plotted on age-growth chart for Members <20 years of age. If indicated, pertinent recommendation or plan of management consistent with the codes used.

(10.20) - Weight Management Visits

Providers may bill for weight management visits for children with BMI >85th percentile. BMI percentile must be measured and documented during that visit. Visits addressing problem-focused care delivered by a physician or an advance practice nurse or physician's assistant billing under a physician, may be billed for care delivered and documented using evidence-based clinical guidelines.

For those in the >85th percentile, payable weight management visits may include a maximum of three visits spread over a course of six months; follow-up visits after the initial one visit must include, in the patient's record, a note addressing the patient's/parent's readiness to change and outcomes of intervention to date. An appropriate CPT code or UB-04 revenue code and appropriate diagnosis codes must be included on the claim form for each visit.

Each visit should include, in-patient record, documentation of educational handouts given, care plan and outcomes based on specific treatment and behavior changes (e.g., nutrition, physical activity etc.) recommended and made, compliance with past recommendations, results of screening laboratory tests, reports of referrals and consultations, if any, and time spent by provider with patient and family during that visit. No further visits related to weight management will be payable after a maximum of three visits over a six month period, unless improvement in BMI percentile is evident based on the diagnosis codes submitted for that claim or documentation of favorable outcome is appended to the claim.

Weight management visits cannot be billed on the same day as a preventive visit. Weight management counseling services can be billed as part of a problem-focused E&M visit using CPT codes 99204- 99205, if provided to a new patient, or 99214-99215 if provided during a follow-up visit to an established patient. CPT guidance on this topic allows for this provision when counseling and/or care coordination dominates (more than 50 percent) face-to-face encounter time with the patient and/or family. The extent of counseling and/or coordination of care (time as well as content of care, coordination and counseling) must be documented in the medical record.

(10.21) - Oral Screening and Dental Referral

An oral screening is part of the well-child visit physical examination, but does not replace referral to a dentist. For children younger than 2-years-old, the dental screening is to identify children who require evaluation by a dentist. Oral health screening for children should be provided as part of the physical examination.

Dental services include services for relief of pain and infections, restoration of teeth, dental sealants, prophylaxis, fluoride supplementation and maintenance of dental health including instruction in self-care oral hygiene procedures.
Comprehensive dental care and preventive dental services are covered benefits for children. Molina provider dental benefits to Members through Avensis. Call (866) 857-8124 to locate a network dentist.

(10.22) - Fluoride Varnishing

Primary care providers can bill for fluoride varnishing as an add-on to well-child visit if they complete training through Bright Smiles program of the Illinois Chapter of the American Academy of Pediatrics. Reimbursement for code D1206 is limited to children younger than 36 months old.

Training is available through webinars. For more information, visit the Bright Smiles page of the ICAAP website at http://illinoisaap.org/projects/bright-smiles/physician-resources/.

(10.23) - 24 Hour Nurse Advice Line

Members may call the Nurse Advice Line anytime they need health care information or are experiencing symptoms which are not life-threatening. Registered nurses are available 24 hours a day, seven days a week, to help make good healthcare decisions and assess symptoms.

Molina is committed to helping our Members:

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

The Nurse Advice Line registered nurses do not diagnose, they assess symptoms and guide the patient to the most appropriate level of care following evidence-based clinical algorithms. 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.

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

Section 11 - Health Education and Disease Management Programs

(11.1) – Molina Healthcare Disease Management Programs

Molina’s Health Education and Disease Management programs will be incorporated into the Member’s treatment plan to address the Member’s health care needs. Molina wants you to be aware of health management programs offered to assist with care management. Molina health management programs provide patient education information to Members and facilitate provider access to these chronic disease programs and services.

We have programs that can help you manage your patient’s condition. These include programs, such as:

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

A Care Manager/Nurse or pharmacist is on hand to teach your patients about their diseases. He/she will manage the care with the Member’s physician, and provide other resources. Members are identified for enrollment in these programs using medical or pharmacy claims, Nurse Advice Line or doctor referral. Members can also ask Molina 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:

- Quality Improvement at (855) 866-5462
- TTY at 711
- Visit www.MolinaHealthcare.com
- Program Eligibility Criteria and Referral Source

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

- Pharmacy claims data
- Encounter data or paid claim with a relevant CPT-4 or diagnosis code
- Member Services welcome calls made by staff to new Member households
- Member self-referral or other inbound calls expressing interest in better health management
- Practitioner/provider referral
- Nurse Advice Line referral
- Medical Case Management or Utilization Management identification

(11.2) - Provider Participation

Coordination of care and appropriate treatment action plans are important to successful health outcomes. Practitioner/provider resources and services may include:

- Annual practitioner/provider feedback letters containing a list of patients identified as potentially appropriate for the health management programs
- 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

(11.3) - Pregnancy Health Management Program - Motherhood Matters®

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.

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® 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® 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.

(11.4) - Smoking Cessation

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

For information about the Molina smoking cessation program or to enroll Members, please contact our Health Education Program Department at (855) 866-5462.

(11.5) - Well Mom Program

The Molina Well Mom program is a multi-faceted program encompassing Member outreach, Member incentives, Member and provider awareness and education. The overarching goals of the Well Mom program are to incorporate evidenced-based practices into improving perinatal and infant outcomes by early identification and intensive care coordination of at-risk Members. Through early identification and intensive care coordination, Molina seeks to promote healthy pregnancies and subsequently prevent adverse birth outcomes such as, but not limited to premature births and low birth weight infants, reducing the need for neonatal intensive care services, and further adverse, related sequelae.

(11.6) - Breathe With Ease

Molina provides an asthma health management program called Breathe With Ease, designed to assist Members in understanding their disease. Molina 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. Breathe With Ease Program Activities include:

Members identified as having high needs have 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 Information and Benefits:

- Clinical Practice Guidelines – Molina uses and recommends the National Heart, Lung and Blood Institute (NHLBI) Asthma Guidelines
- Asthma Registry – Molina has an asthma registry. The registry uses available claims and pharmacy information to identify and track asthma Members in the program
- Asthma Newsletters – Molina distributes asthma newsletters to identified Members
- Care Reminders and Age-Appropriate Tools – Molina provides individualized reminders and educational tools to Members with asthma
- Asthma Education – Asthma education is available for all Molina Members. We encourage providers to refer patients to these services, especially for newly diagnosed asthmatics or those having difficulty managing their disease.

(11.7) - Healthy Living with Diabetes

Molina’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 adopted the American Diabetes Association (ADA) guidelines for diabetic care
• Diabetes Registry – Molina established a diabetes registry. The registry uses available claims and pharmacy information to identify and track diabetic Members in the program
• Diabetes Newsletters – Molina distributes newsletters to diabetic Members
• Care Reminders and Age-Appropriate Tools – Molina provides individualized reminders and educational tools to Members with diabetes
• Diabetes Education – Diabetes education is available for all Molina Members. We encourage providers to refer patients to these services, especially for newly diagnosed diabetics or those having difficulty managing their disease
• 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 diabetic patients not included in the profile.

(11.8) - Heart Healthy Living

Molina’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 has chosen to target three subprograms: heart failure, coronary artery disease (CAD) and hypertension. 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 adopted the NHLBI and the American Heart Association guidelines for cardiovascular care.
• Cardiovascular Disease Registry – Molina established a CVD registry. The registry uses available claims and pharmacy information to identify and track cardiovascular Members in the program
• Care Reminders and Tools – Molina provides individualized reminders and educational tools to Members with CVD
• Cardiovascular Disease Education information – CVD education is available for all Molina Members. We encourage providers to refer patients to these services, especially for newly diagnosed heart disease or those having difficulty managing their disease

(11.9) - Healthy Living with COPD

Given the diversity of Molina’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’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 adopted the Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines for COPD care
- COPD Registry – Molina established a COPD registry. The registry uses available claims and pharmacy information to identify and track COPD Members in the program
- Care Reminders and Appropriate Tools – Molina provides individualized reminders and educational tools to Members with COPD
- Smoking Cessation – For information about the Molina smoking cessation program or to enroll Members, please contact our Health Education Program Department

**Section 12 - Transportation**

**(12.1) - Non-Emergency Medical Transportation**

Molina provides free transportation for Members to the following:

- Scheduled doctor’s appointments
- Pharmacy
- DME provider
- WIC appointments (before/after pregnancy)

Non-Emergency transportation is provided through Secure Transportation. If one of your HealthChoice Illinois patients is in need of this service please have them call Secure directly at (844) 644-6354. For further assistance HealthChoice Illinois Members can call (855) 687-7861 TTY 711, and one of our Member Service Representatives will assist them with this request.

Some non-emergency transportation services require prior approval and all patients should call at least three business days in advance of when the services are needed. Rides for discharge from hospital can be scheduled with three hours’ notice.

**(12.2) - 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.

Examples of conditions considered for emergency transportation 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 13 – Provider Responsibilities**

**(13.1) - Nondiscrimination of Healthcare Service Delivery**

Molina complies with the guidance set forth in the final rule for Section 1557 of the ACA, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina website home pages. Providers who join the Molina Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Please see the Cultural Competency and Linguistic Services section of this manual for more information.

**(13.2) - Facilities, Equipment and Personnel**

The provider’s facilities, equipment, personnel and administrative services must be at a level and quality necessary to perform duties and responsibilities to meet all applicable legal requirements including the accessibility requirements of the Americans with Disabilities Act (ADA).
(13.3) - Provider Data Accuracy and Validation

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

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

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

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

Please visit our Provider Online Directory at [https://providersearch.molinahealthcare.com](https://providersearch.molinahealthcare.com) to validate your information. Please notify your Provider Network Manager if your information needs to be updated or corrected. Providers may also send their information updates via email to IllinoisProviders@MolinaHealthcare.com.

Molina is required to audit and validate our Provider Network data and Provider Directories on a routine basis. As part of our validation efforts, we may reach out to our network of providers through various methods, such as: letters, phone campaigns, face-to-face contact, fax and fax-back verification, etc. Providers are required to provide timely responses to such communications.

(13.4) - Molina Electronic Solutions Requirements

Molina requires providers to utilize electronic solutions and tools.

Molina requires all contracted providers to participate in and comply with Molina’s Electronic Solution Requirements, which include, but are not limited to, electronic submission of prior authorization requests, health plan access to electronic medical records (EMR), electronic claims submission, electronic fund transfers (EFT), electronic remittance advice (ERA) and registration for and use of Molina’s Provider Web Portal (Provider Portal).

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

Any provider insisting on paper claims submission and payment via paper check will be ineligible for contracted provider status within the Molina network.

Any provider entering the network as a contracted provider will be required to comply with Molina’s Electronic Solution Policy by registering for Molina’s Provider Web Portal, and submitting electronic claims upon entry into...
Providers entering the network as a contracted provider must enroll for EFT/ERA payments within thirty (30) days of entering the Molina network.

(13.5) - Electronic Solutions/Tools Available to Providers

- Electronic Tools/Solutions available to Molina providers include:
  - Electronic Claims Submission Options
  - Electronic Payment (Electronic Funds Transfer) with Electronic Remittance Advice (ERA)
  - Provider Web Portal

(13.6) - Electronic Claims Submission Requirement

Molina requires Participating providers to submit claims electronically. Electronic claims submission provides significant benefits to the provider including:

- Ensures HIPAA compliance
- Helps to reduce operational costs associated with paper claims (printing, postage, etc.)
- Increases accuracy of data and efficient information delivery
- Reduces Claim delays since errors can be corrected and resubmitted electronically
- Eliminates mailing time and Claims reach Molina faster

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina Healthcare of Illinois via the Provider Portal. See our Provider Web Portal Quick Reference Guide [https://provider.molinahealthcare.com](https://provider.molinahealthcare.com) or contact your Provider Network Manager for registration and Claim submission guidance.

While both options are embraced by Molina, providers submitting claims via Molina’s Provider Portal (available to all providers at no cost) offers a number of claims processing benefits beyond the possible cost savings achieved from the reduction of high-cost paper claims including:

- Ability to add attachments to claims
- Submit corrected claims
- Easily and quickly void claims
- Check claims status
- Receive timely notification of a change in status for a particular claim

(13.7) - EDI Claims Submission Issues

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

(13.8) - Electronic Payment (EFT/ERA) Requirement

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

Below is the link to register with Change Healthcare ProviderNet to receive electronic payments and remittance advices. Additional instructions on how to register are available under the EDI/ERA/EFT tab on Molina’s website: [www.molinahealthcare.com](http://www.molinahealthcare.com).

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

(13.9) - Provider Web Portal

Providers are required to register for and utilize Molina’s Provider Web Portal (Provider Portal). The Provider Portal is an easy to use, online tool available to all of our providers at no cost. The Provider Portal offers the following functionality:

- Verify and print member eligibility
- Claims Functions
  - Professional and Institutional Claims (individual or multiple claims)
  - Receive notification of Claims status change
  - Correct Claims
  - Void Claims
  - Add attachments to previously submitted claims
  - Check Claims status
  - Export Claims reports
  - Appeal Claims
- Prior Authorizations/Service Requests
  - Create and submit Prior Authorization Requests
  - Check status of Authorization Requests
  - Receive notification of change in status of Authorization Requests
- View HEDIS® Scores and compare to national benchmarks

(13.10) - Balance Billing

Providers contracted with Molina cannot bill the Member for any covered benefits. The provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers may not charge Members fees for covered services. Providers agree that under no circumstance shall a Member be liable to the provider for any sums owed by Molina to the provider. Balance billing a Molina Member for services covered by Molina is prohibited. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the provider’s usual and customary fees.

For additional information please refer to the Compliance and Claims and Compensation sections of this Provider Manual.

(13.11) - Member Information and Marketing
Any written informational or marketing materials directed to Molina Members must be developed and distributed in a manner compliant with all State and Federal Laws and regulations and be approved by Molina prior to use. Please contact your Provider Network Manager for information and review of proposed materials.

(13.12) - Member Rights and Responsibilities

Providers are required comply with the Member Rights and Responsibilities as outlined in Member materials (such as in the Member Handbook). A link to these rights and responsibilities is available in the Member Rights and Responsibilities section of this manual.

(13.13) - Member Eligibility Verification

Providers should verify eligibility of Molina Members prior to rendering services. Payment for services rendered is based on enrollment and benefit eligibility. The contractual agreement between providers and Molina places the responsibility for eligibility verification on the provider of services.

Possession of a Molina ID Card does not guarantee Member eligibility or coverage. A provider must verify a recipient’s eligibility each time the recipient presents to their office for services. More information on Member eligibility verification options is available in the Enrollment into Managed Care Programs section of this manual.

(13.14) - Healthcare Services (Utilization Management and Case Management)

Providers are required to participate in and comply with Molina’s Healthcare Services programs and initiatives. Clinical documentation necessary to complete medical review and decision making is to be submitted to Molina through electronic channels such as the Provider Portal. Clinical documentation can be attached as a file and submitted securely through the Provider Portal. Please see the Medical Management section of the Manual for additional details about these and other Healthcare Services programs.

(13.15) - In Office Laboratory Tests

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

For more information about In-Network Laboratory Providers, please consult the Molina Provider Directory (https://providersearch.molinahealthcare.com/). For testing available through In-Network Laboratory Providers, or for a list of In-Network Laboratory provider patient services centers, please reach out to the In-Network Laboratory provider.

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

(13.16) - Referrals

A referral is necessary when a provider determines Medically Necessary services are beyond the scope of the PCP’s practice or it is necessary to consult or obtain services from other in-network specialty health professionals (please refer to Medical Management section of this Manual). Information is to be exchanged between the PCP and Specialist to coordinate care of the patient to ensure continuity of care. Providers
need to document in the patient’s medical record any referrals that are made. Documentation needs to include the specialty, services requested, and diagnosis for which the referral is being made.

Providers should direct Members to health professionals, hospitals, laboratories, and other facilities and providers which are contracted and credentialed (if applicable) with Molina Healthcare. In the case of urgent and Emergency Services, providers may direct Members to an appropriate service including but not limited to primary care, urgent care and Emergency Services. There may be circumstances in which referrals may require an out of network provider; prior authorization will be required from Molina except in the case of Emergency Services.

PCPs are able to refer a Member to an in-network specialist for consultation and treatment without a referral request to Molina.

(13.17) - Admissions

Providers are required to comply with Molina’s facility admission, prior authorization, and Medical Necessity review determination procedures.

(13.18) - Participation in Utilization Review and Care Management Programs

Providers are required to participate in and comply with Molina’s utilization review and Care Management programs, including all policies and procedures regarding prior authorizations. This includes the use of an electronic solution for the submission of documentation required for medical review and decision making. Providers will also cooperate with Molina in audits to identify, confirm, and/or assess utilization levels of covered services.

(13.19) - Continuity and Coordination of Provider Communication

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

(13.20) - Treatment Alternatives and Communication with Members

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

(13.21) - Prescriptions

Providers are required to adhere to Molina’s drug formularies and prescription policies.

(13.22) - Pain Safety Initiative (PSI) Resources

Safe and appropriate opioid prescribing and utilization is a priority for all of us in health care. Molina requires providers to adhere to Molina’s drug formularies and prescription policies designed to prevent abuse or misuse of high-risk chronic pain medication. Providers are expected to offer additional education and support to Members regarding Opioid and pain safety as needed.
Molina is dedicated to ensuring providers are equipped with additional resources, which can be found on the Molina Healthcare provider website. Providers may access additional Opioid-safety and Substance Use Disorder resources at www.MolinaHealthcare.com under the Health Resource tab. Please consult with your Provider Network Manager or reference the medication formulary for more information on Molina’s Pain Safety Initiatives.

(13.23) - Participation in Quality Programs

Providers are expected to participate in Molina’s Quality Programs and collaborate with Molina in conducting peer review and audits of care rendered by providers.

Additional information regarding Quality Programs is available in the Quality Improvement section of this Manual.

(13.24) - Site and Medical Record-Keeping Practice Reviews

As a part of Molina’s Quality Improvement Program, providers are required to maintain compliance with certain standards for safety, confidentiality, and record keeping practices in their practices.

Providers are required to maintain an accurate and readily available individual medical record for each Member to whom services are rendered. Providers are to initiate a medical record upon the Member’s first visit. The Member’s medical record (electronic preferred or hard copy) should contain all information required by State and Federal Law, generally accepted and prevailing professional practice, applicable government sponsored health programs and all Molina’s policies and procedures. Providers are to retain all such records for a minimum of ten (10) years and retained further if the records are under review or audit until the review or audit is complete.

CMS has specific guidelines for the retention and disposal of Medicare records. Please refer to CMS General Information, Eligibility, and Entitlement Manual, Chapter 7, Chapter 30.30 for guidance.

(13.25) - Delivery of Patient Care Information

Providers must comply with all State and Federal Laws, and other applicable regulatory and contractual requirements to promptly deliver any Member information requested by Molina for use in conjunction with utilization review and management, grievances, peer review, HEDIS® Studies, Molina’s Quality Programs, or claims payment. Providers will further provide direct access to patient care information (hard copy or electronic) as requested by Molina and/or as required to any governmental agency or any appropriate State and Federal authority having jurisdiction.

(13.26) - Compliance

Providers must comply with all State and Federal Laws and regulations related to the care and management of Molina Members.

(13.27) - Confidentiality of Member Protected Health Information (PHI) and HIPAA Transactions

Molina requires that providers respect the privacy of Molina Members (including Molina Members who are not patients of the provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member PHI.
Additionally, providers must comply with all HIPAA TCI (transactions, code sets, and identifiers) regulations. Providers must obtain a National Provider Identifier (NPI) and use their NPI in HIPAA Transactions, including claims submitted to Molina.

**13.28 - Participation in Grievance and Appeals Programs**

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

**13.29 - Delegation**

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

This section describes Molina’s established standards on access to care, site relocations, medical record keeping and Member marketing information for participating providers.

**13.30 - Non-Discrimination Statement**

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 must receive 30 days advance notice from the provider.

(13.31) - Access to Care Standards

Molina is committed to providing timely access to care for all Members in a safe and healthy environment. Molina will ensure providers offer hours of operation no less than offered to commercial Members. Access standards have been developed to ensure that all healthcare services are provided in a timely manner. The provider or designee must be available 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 audits access to care, please refer to the Quality Improvement section of this manual.

<table>
<thead>
<tr>
<th>Visit Type</th>
<th>Access Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care</td>
<td>Within 24 Hours</td>
</tr>
<tr>
<td>Non-Urgent Routine Care</td>
<td>Within 3 weeks of request</td>
</tr>
<tr>
<td>Well Child/Adolescent Preventive Care</td>
<td>Within 2 weeks of request</td>
</tr>
<tr>
<td>Adult Preventive Care</td>
<td>Within 5 weeks of request</td>
</tr>
<tr>
<td>Specialist</td>
<td>Within 3 weeks of request</td>
</tr>
<tr>
<td>Prenatal Care 1st Trimester – Initial Visit</td>
<td>Within 2 weeks</td>
</tr>
<tr>
<td>2nd Trimester – Initial Visit</td>
<td>Within 1 week</td>
</tr>
<tr>
<td>3rd Trimester – Initial Visit</td>
<td>Within 3 days</td>
</tr>
<tr>
<td>Behavioral Health Care</td>
<td></td>
</tr>
<tr>
<td>Non-life-threatening BH emergencies</td>
<td>Within 6 hours of request</td>
</tr>
<tr>
<td>Urgent BH visits</td>
<td>Within 48 hours of request</td>
</tr>
<tr>
<td>Routine BH visits</td>
<td>Within 10 days of request</td>
</tr>
<tr>
<td>Follow-Up Routine BH visits</td>
<td>Within 30 days of request</td>
</tr>
</tbody>
</table>

(13.32) - Relocations and Additional Sites

Providers should notify Molina 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.

(13.33) - Site and Medical Record-Keeping Practice Reviews

As a part of Molina’s Quality Improvement (QI) program, providers are required to maintain compliance with certain standards for safety, confidentiality, and record keeping practices in their practices.

(13.4) - Member Information and Marketing

Any written informational and marketing materials directed at Molina Members must be developed at a sixth grade reading level and have prior written consent from Molina and the appropriate government agencies. Please contact your Provider Network Manager for information and review of proposed materials. Neither Molina, 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 14 – Medical Management**

(14.1) - Introduction

Molina maintains a medical management program to ensure patient safety as well as detect and prevent fraud, waste and abuse in its programs. The Molina medical management program also ensures that Molina only reimburses for services identified as a covered benefit and medically necessary. Elements of the Molina medical management program include medical necessity review, prior authorization, inpatient management and restrictions on the use of non-network providers.

(14.2) - Medical Necessity Review

In conjunction with regulatory guidance from the Centers for Medicare and Medicaid Services (CMS) and industry standards, Molina only reimburses services provided to its Members that are medically necessary. Molina may conduct a medical necessity review of all requests for authorization and claims, within the specified timeframe governed by Federal or State law for all lines of business. This review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively, as long as the review complies with Federal or State regulations and the Molina Hospital or Provider Network Management Agreement.

(14.3) - Clinical Information

Molina requires copies of clinical information be submitted for documentation in all medical necessity determination processes. Clinical information includes but is not limited to; physician emergency department notes, inpatient history/physical exams, discharge summaries, physician progress notes, physician office notes, physician orders, nursing notes, results of laboratory or imaging studies, therapy evaluations and therapist notes. Molina does not accept clinical summaries, telephone summaries or inpatient case manager criteria reviews as meeting the clinical information requirements unless required by State regulation or the Molina Hospital or Provider Network Management Agreement.

(14.4) - Prior Authorization

Molina requires prior authorization for specified services as long as the requirement complies with Federal or State regulations and the Molina Hospital or Provider Network Management Agreement. The list of services that require prior authorization is available in narrative form, along with a more detailed list by CPT and HCPCS codes. Molina prior authorization documents are updated at least annually and the current documents are posted on the Molina website. Molina has included at the end of this section of this manual, links to the current Authorization Request form on the Molina website. Providers may also send in authorization requests through our web portal system. Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Federal and State law) are excluded from the prior authorization requirements. Molina does not “retroactively” authorize services that require prior authorization.

Currently Molina will process any non-urgent requests within 10 days of receipt of request. Urgent requests will be processed within 72 hours. Beginning 1/1/2018 Molina will process any non-urgent requests within four (4) days of receipt of request. Urgent requests will be processed within 48 hours.
Providers who request Prior Authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina has a full-time Medical Director available to discuss medical necessity decisions with the requesting provider at (855) 866-5462.

(14.5) - Requesting Prior Authorization

Web Portal: Providers are encouraged to use the Molina Web Portal for prior authorization submission. Instructions for how to submit a Prior Authorization Request are available on the Web Portal.

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

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

Mail: Prior Authorization requests and supporting documentation can be submitted via mail at the following address:

Molina Healthcare of Illinois
Attn: Health Care Services Dept.
1520 Kensington Road Suite 212
Oak Brook, IL 60523

(14.6) - Inpatient Management

(14.6.1) - Elective Inpatient Admissions

Molina requires prior authorization for all elective inpatient admissions to any facility. Elective inpatient admission services performed without prior authorization may not be eligible for payment.

(14.6.2) - Emergent Inpatient Admissions

Molina requires notification of all emergent inpatient admissions within 24 hours of admission or by the close of the next business day when emergent admissions occur on weekends or holidays. Molina requires that notification includes Member demographic information, facility information, date of admission and clinical information (see definition above) sufficient to document the medical necessity of the admission. Emergent inpatient admission services performed without meeting notification and medical necessity requirements will result in a denial of authorization for the inpatient admission.

(14.6.3) - Concurrent Inpatient Review

Molina performs concurrent inpatient review in order to ensure patient safety, medical necessity of ongoing inpatient services, and adequate progress of treatment and development of appropriate discharge plans. Performing these functions requires timely clinical information updates from inpatient facilities. Molina will request updated original clinical records from inpatient facilities at regular intervals during a Member’s inpatient admission. Molina requires that requested clinical information updates be received by Molina from the inpatient facility within 24 hours of the request. Failure to provide timely clinical information updates will result in denial of authorization for the remainder of the inpatient admission.

(14.7) - Readmission Policy
Hospital readmissions within 30 days have been found by CMS to potentially constitute a quality of care problem. Readmission review is an important part of Molina’s Quality Improvement Program to ensure that Molina Members are receiving hospital care that is compliant with nationally recognized guidelines, Medicare regulations, State Medicaid regulations and CMS.

Molina will review all hospital subsequent admissions within the specified timeframe governed by State law for all Medicaid claims and those State statutes, regulations, and/or requirements as set forth in each state’s Medicaid contracts with either the federal government and/or contracted health plans, regarding hospital subsequent admissions for Medicaid claims are incorporated by reference herein.

To the extent allowed by State law and the terms of the Hospital or Provider Network Management Agreement between the Hospital and Molina, Molina will implement the readmission program pursuant to Medicare regulations and CMS for all Medicaid claims. Therefore in Illinois, Molina will review all hospital subsequent admissions that occur within 30 days of the previous discharge for all Medicaid claims.

If the subsequent hospital admission is determined to be a readmission, Molina will deny the subsequent admission or pay for the subsequent admission and seek money from the first provider if they are different providers, unless it meets one of the exceptions noted below, violates federal or state law, CMS regulations or the terms of the Hospital or Provider Network Management Agreement between the Hospital and Molina.

(14.8) - Exceptions:

1. The readmission is determined to be due to an unrelated condition from the first inpatient admission and there is no evidence that premature discharge or inadequate discharge planning in the first admission necessitated the second admission

2. The readmission is part of a medically necessary, prior authorized or staged treatment plan

3. There is clear medical record documentation that the patient left the hospital against medical advice during the first hospitalization prior to completion of treatment and discharge planning.

(14.9) - Definitions:

Readmission: A subsequent admission to an acute care hospital within a specified timeframe of a prior admission for a related condition or as readmission is defined by State laws or regulations.

Related Condition: A condition that has a same or similar diagnosis or is a preventable complication of a condition that required treatment in the original hospital admission.

(14.10) - Non-Network Providers

Molina maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process in order to provide medical care for Molina Members. Molina requires Members to receive medical care within the participating, contracted network of providers. All care provided by non-contracted, non-network providers must be prior authorized by Molina.

Non-network providers may provide emergent/urgent care and dialysis services for a Member who is temporarily outside the service area, without prior authorization or as otherwise required by Federal or State laws or regulations.

(14.11) - 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 does not reward providers or other individuals for issuing denials of coverage or care. Furthermore, Molina 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.

(14.12) - Coordination of Care

Molina’s Integrated Care Management, which includes Utilization Management, Case Management and Disease 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 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. Molina staff coordinates care in partnership with providers and Members to ensure efforts are efficient and non-duplicative.

(14.13) - Continuity of Care and Transition of Members

It is Molina’s policy to provide Members with advance notice when a provider they are seeing will no longer be in network. Members and providers are encouraged to use this time to transition care to an in-network provider. The provider leaving the network shall provide all appropriate information related to course of treatment, medical treatment, etc. to the provider(s) assuming care. Under certain circumstances, Members may be able to continue treatment with the out of network provider for a given period of time. For additional information regarding continuity of care and transition of Members, please contact Molina at (855) 866-5462.

(14.14) - Continuity and Coordination of Provider Communication

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

(14.15) - Case Management

Molina 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 adheres to Case Management Society of America Standards of Practice Guidelines in its execution of the program.

The Molina 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 case manager will arrange individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina 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.

(14.15.1) - 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 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)
- Preterm births
- High-technology home care requiring more than two weeks of treatment
- Member accessing ER services inappropriately
- Children with Special Health Care Needs

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

Phone: (855) 866-5462
Fax: (855) 556-2073

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.

(14.15.2) - 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

(14.15.3) - Family Case Management

The Illinois Department of Human Services (DHS) contracts with local health departments and Federally Qualified Health Centers (FQHC) to provide Family Case Management (FCM) services to pregnant women, infants and children with high-risk conditions who are eligible for HFS medical programs.

FCM providers are responsible for providing face-to-face services and ongoing assistance to families to remove barriers to receiving preventive health care services, providing education about the importance of child health including appropriate immunizations and screenings, parenting classes, nutritional counseling and education about prenatal care.

Molina will coordinate services and share information with FCM providers and conduct periodic meetings with FCM providers to ensure high-quality services are provided to Members.

(14.16) - Women, Infants and Children (WIC) Program

DHS administers the Women, Infants and Children (WIC) program in Illinois. WIC seeks to improve the health status of women, infants and children, promote breastfeeding, reduce the incidence of infant mortality, premature births and low birth weight, and to aid in the development of children. The WIC target populations are low-income, nutritionally at risk:

- Pregnant women (through pregnancy and up to six weeks after birth or after pregnancy ends)
- Breastfeeding women (up to infant’s first birthday);
- Non-breastfeeding postpartum women (up to six months after the birth of an infant or after pregnancy ends)
- Infants (up to their first birthday)
- Children (up to their fifth birthday)

Providers are encouraged to refer patients included in the targeted population for WIC evaluation.

(14.17) - Early Intervention

Early Intervention (EI) is a DHS program that helps children younger than 36 months of age to meet developmental milestones. The EI program empowers parents to help their children overcome challenges that may put them at a substantial risk for delays. Children eligible for EI services experience delays in at least one of these areas:

- Cognitive development
- Physical development, including vision and hearing
- Language and speech development; psychosocial development
- Self-help skills
- Diagnosed with a physical or mental condition with a high probability of resulting in developmental delays
- Mother diagnosed with a major depression

Families access the Illinois Early Intervention Services System through a DHS Child and Family Connections (CFC) office in their local area. These regional offices provide:

(14.18) - Service coordination
• Assistance with eligibility determination and coordinate the development of the initial and annual
• Individualized Family Service Plans (IFSP), which list EI services needed by the child and family,
  including transportation for those services identified in the child’s IFSP

Under Part C of the Individuals With Disabilities Education Act, health care providers are required to make a
referral to Early Intervention within two (2) working days after a child has been identified with a disability or
possible developmental delay.

(14.19) – School-Based/Linked Health Centers

DHS funds school-based/linked health centers provide routine medical exams, physical exams for school or
sports, treatment of acute illness, immunizations, sexually transmitted diseases (STD) testing and treatment,
gynecological exams, pregnancy testing, mental health services and referrals.

School-Based/Linked Health Center services are direct access for HealthChoice Illinois Members younger than
20 years old. DHS monitors the health centers to ensure continued compliance with Illinois Standards for
School Health Services. Covered services are:

• EPSDT Services as defined in the Handbook for Providers of Healthy Kids
• Immunizations
• Basic Laboratory Tests
• Screening and Treatment of Sexually Transmitted Diseases
• Family Planning Services
• Acute Management and on-going monitoring of chronic conditions, such as asthma, diabetes
• and seizure disorders
• Maternity Care (Prenatal and Postpartum)
• Dental Services

(14.20) - Emergency Services

Emergency services are covered on a 24-hour basis without the need for prior authorization for all Members
experiencing an emergency medical situation.

Utilization Management service is available during business hours and a 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, Inc. contracts with vendors that provide 24-hour emergency
services for ambulance and hospitals. In the event that our Member is outside of the service area, Molina is
prepared to authorize treatment to ensure that the patient is stabilized.

(14.21) - 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 his/her 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.

(14.22) - Medical Necessity Standards

**Medically Necessary** means a service that is appropriate, no more restrictive than that used in the state Medicaid program, including:

- quantitative and non-quantitative treatment limits,
- as indicated in State statutes and regulations, the State Plan, and other State policy and procedures, and
- meets the standards of good medical practice in the medical community, as determined by the provider in accordance with Contractor’s guidelines, policies, or procedures, for the diagnosis or treatment of a covered illness or injury;
- for the prevention of future disease;
- to assist in the Enrollee’s ability to attain, maintain, or regain functional capacity;
- for the opportunity for an Enrollee receiving LTSS to have access to the benefits of community living,
- to achieve person-centered goals, and live and work in the setting of the Enrollee’s choice;
- or for an Enrollee to achieve age-appropriate growth and development.

(14.23) - Specialty Pharmaceuticals/Injectables and Infusion Services

Many self-administered and office-administered injectable products require Prior Authorization (PA). In some cases they will be made available through Molina’s vendor, CVS Health Specialty or Accredo Specialty Pharmacy.

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

(14.24) - Prior Authorization Guidelines and Prior Authorization Request Form

The Molina Drug Formulary, Prior Authorization Codification List and Request Form may be found on the Molina website or by using the following link:
www.molinahealthcare.com/providers/il/medicaid/forms/Pages/fuf.aspx

Section 15 – Quality Improvement

(15.1) - Quality Improvement Department

Molina maintains a Quality Improvement (QI) Department to work with Members and practitioners/providers in administering the Molina Quality Improvement Program (QIP). This Provider Manual contains excerpts from the Molina QIP. For a complete copy Molina’s QIP you can contact your Molina Provider Network Management Department toll free at (855) 866-5462. You can also make a request by fax at (866) 617-4969.
Molina Healthcare of Illinois

Quality Improvement Department

1520 Kensington Rd., Suite 212

Oak Brook, IL 60523

The address for mail requests is:

Molina 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 does not delegate QI activities to Medical Groups/IPAs. However, Molina 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 QIP including reporting of access and availability and provision of medical records as part of the HEDIS® review process in support of health care operations per HIPAA.
- Allow access to Molina QI personnel for site and medical record review processes

(15.2) - Medical Records

Molina requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to Members is consistently documented and that necessary information is readily available in the medical record. All entries will be indelibly added to the Member’s record. Molina 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 healthcare;
- Storage maintenance and disposal; and
- Process for archiving medical records and implementing improvement activities.

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

(15.3) - 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 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

(15.4) - 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

(15.5) - Retrieval

- The medical record is available to practitioner/provider at each encounter
- The medical record is available to Molina for purposes of quality improvement
- The medical record is available to the Illinois Department of Healthcare and Family Services

(15.6) - Services

- (HFS) 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

(15.7) - Confidentiality

- Medical Records are protected from unauthorized access
- Access to confidential information is restricted
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health Information. Molina is notified of any potential breach.
- Signed end user agreements are in place for Molina staff that have access to EMR/EHR systems
Additional information on medical records is available from your local Molina QI Department. Contact Molina toll free at (855) 866-5462, and press 0 after choosing the line of business to be directed to the MRR team. See the HIPAA/Security section for additional information regarding the Health Insurance Portability and Accountability Act (HIPAA).

(15.8) - Access to Care

Molina 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 in Section 13 (Provider Responsibilities) to ensure that healthcare services are provided in a timely manner. The standards are based on 95 percent availability for emergency services and 90 percent or greater for all other services. The PCP or their designee must be available 24 hours a day, seven days a week to Members.

(15.9) - Appointment Access

All practitioners/providers who oversee the Member’s healthcare are responsible for providing the following appointments to Molina Members in the timeframes noted in the Provider Responsibilities section.

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

Additional information on appointment access standards is available from Molina Provider Network Management Department toll free at (855) 866-5462.

(15.10) - Office Wait Time

For scheduled appointments, the wait time in offices should not exceed 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.

(15.11) - After Hours

All practitioners must have back-up (on call) coverage after hours or during the practitioner’s absence or unavailability. Molina requires practitioners to maintain a 24-hour phone service, seven 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 30 minutes.

(15.12) - 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 Member Services Department at (855) 687-7861.
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.

(15.13) - Women’s Open Access

Molina allows direct access to a Women’s Health Care Provider (WHCP) for routine and preventative women’s healthcare Covered Services when a female Enrollee’s Primary Care Provider is not a WHCP.

Additional information on access to care is available under the Resources tab at www.MolinaHealthcare.com or from your local Molina Provider Network Management Department toll free at (855) 866-5462.

(15.14) - Site and Medical Record-Keeping Practice

Molina has a process to ensure that the offices of all practitioners meet its office-site and medical record keeping practices standards. Molina assesses the quality, safety and accessibility of office sites where care is delivered when there are Member grievances identified related to office/site quality. 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 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 assesses one medical/treatment records for orderliness of record and documentation practices. To ensure Member
confidentiality, Molina reviews a “blinded” medical/treatment record or a “model” record instead of an actual record.

(15.15) - Improvement Plans/ Corrective Action Plans (CAP)

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 within 30 calendar days
- Send notification that another review will be conducted of the office in six months

When compliance is not achieved, the practitioner will be required to submit a written CAP to Molina within 30 calendar days of notification by Molina. 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-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 Fair Hearing Plan policy.

(15.16) - Advance Directives (Patient Self-Determination Act)

(15.16.1) - Advance Directives

Practitioners/providers must inform patients of their right to make healthcare decisions and execute advance directives. It is important that Members are informed about advance directives. During routine medical record review, Molina auditors will look for documented evidence of discussion between the practitioner/provider and the Member. Molina 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 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’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 or the state survey and certification agency if the Member is dissatisfied with Molina’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 healthcare. Under Illinois State Law, there are three kinds of directives – Healthcare Power of Attorney, Living will, and Mental Health Treatment Preference Declaration. 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. Members may select a new PCP if the assigned provider has an objection to the beneficiary’s desired decision. Molina will facilitate finding a new PCP or specialist as needed.

(15.16.2) - Health Care Power of Attorney

This advance directive names another person to make medical decisions on behalf of Members when they cannot make health care decisions for themselves. It can include plans about the care a Member wants or does not want and include information such as a request for no artificial life-support or organ donation at the time of death. This form must be signed, dated and witnessed. The health care power of attorney in Illinois does not require a notary public to be valid. It only requires that a witness sign the document.

(15.16.3) - Living Will

This advance directive documents the Member’s wishes to die naturally without life-prolonging care if the Member has a terminal condition. 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 will not gain financially from the Member’s death and are not responsible for the Member’s medical care or medical care costs.

(15.16.4) - Practitioner Order for Life-Sustaining Treatment (POLST)

This is an advance directive that documents a Member’s wishes for medical treatment at the time it is completed. It is recommended as an additional document to the Health Care Power of Attorney. This document is usually completed with the Member’s physician or practitioner. This document directs others what to do with the Member at home, or other location, with respect to cardiopulmonary arrest, medical interventions and artificial hydration and nutrition. This document should be placed in a prominent location in the Member’s home, to be used by emergency health care services. The POLST requires the date of discussion of the health care preferences, the documentation of the discussion and the practitioner’s signature.

(15.16.5) - 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, as determined by 2 physicians. It also allows Members to say whether they wish to be admitted to a mental health facility for up to 17 days of treatment. This form designates an “attorney-in-fact” to make decisions regarding mental health treatment of the Member if the Member is unable to give informed consent. This directive must be signed, dated, and witnessed by two people who know the Member well and meet the requirements to be a witness. Witnesses cannot be relatives, possible heirs, healthcare providers or employees of a healthcare facility in which the Member resides or the Member’s attending physician or mental health provider or a relative of the physician or mental health provider. This advance directive can be revoked in part or in total.

(15.16.6) - When There Is No Advance Directive:

When the Member is unable to make health care decisions for themselves, the Illinois Health Care Surrogate Act (755 ILCS 40/25) describes the order in which another person can make a health care decision for the Member. The surrogate decision maker should decide on the best plan of care for the Member based on information they may know about the Member’s end-of-life wishes. The priority order for surrogate decision maker in Illinois is:

- Patient’s guardian of person
• Patient’s spouse or partner of a registered civil union
• Adult child
• Parent
• Adult sibling
• Adult grandchild
• A close friend of the patient
• The patient’s guardian of the estate

(15.17) - Monitoring for Compliance with Standards

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

(15.18) - Quality Improvement Activities and Programs

Molina maintains an active Quality Improvement Program (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.

(15.19) - Clinical Practice Guidelines

Molina uses and promotes Clinical Practice Guidelines (CPGs) to reduce inter-practitioner/provider variation in diagnosis and treatment. CPG adherence is reviewed and 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 CPGs include the following:

• Asthma
• Chronic Obstructive Pulmonary Disease (COPD)
• Depression
• Hypertension
• ADHD
• Congestive Heart Failure in Adults
• Coronary Artery Disease
• Management of Obesity for Adults
• Diabetes
• Smoking Cessation
• Behavioral Health
• Psychotropic Medication Management
• Clinical Pharmacy Medication Review
• Coordination of HCBS
• Dental Services
• Pharmacy Services

The adopted CPGs are distributed to the appropriate practitioners, providers, provider groups, staff model facilities, delegates and Members by the Quality, Provider Network Management, Health Education and Member Services Departments. The guidelines are disseminated through provider newsletters, Just the Fax electronic bulletins and other media and are available on the Molina Website. Individual practitioners or Members may request copies from your local Molina Quality Department toll free at (855) 866-5462.

(15.20) - Preventive Health Guidelines

Molina provides coverage of preventive procedures immunizations based on recommendations published by the United States Preventive Services Task Force (USPSTF) A and B Recommendations and in accordance with the Centers for Medicare & Medicaid Services (CMS) guidelines. Molina uses the Centers for Disease Control (CDC) for immunization schedules. Molina Preventive Health Guidelines include but are not limited to:

• Preventive Services for Adults
• Care for adults 20-64 years old
• Care for adults 65 years and older
• Adult Immunization Schedule
• Preventive Services for Children and Adolescents
• Care for Children up to 24 months
• Care for children 2-19 years old
• Child/Adolescent Immunization Schedules
• Routine Prenatal Care

All guidelines are updated when there are new recommendations by the USPSTF, CMS or the CDC. Guidelines are reviewed and approved by the Clinical Quality Improvement Committee. On an annual basis, Preventive Health Guidelines are distributed to practitioners/providers via www.MolinaHealthcare.com and this manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina provider newsletter.

(15. 21) - Cultural and Linguistic Services

Molina 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 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’s Member Services Department at (855) 687-7861. 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 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, from your local Provider Network Management Representatives and from the Molina Member Services Department.

(15.22) - Measurement of Clinical and Service Quality

Molina monitors and evaluates the quality of care and services provided to Members through the following mechanisms:

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Provider Satisfaction Survey
- Performance Improvement Projects
- Effectiveness of Quality Improvement Initiatives

Molina Healthcare’s most recent results can be obtained from your local Molina Provider Network Management Team toll free at (855) 866-5462.

Contracted Providers and Facilities must allow Molina 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.

(15.23) - HEDIS®

Molina utilizes the NCQA© HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual activity conducted in the spring. The data comes from on-site medical record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of healthcare service including immunizations, women’s health screening, prenatal visits, diabetes care, and care for cardiovascular disease.

HEDIS® results are used in a variety of ways. They are the measurement standard for many of Molina’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.

(15.24) - CAHPS®

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

(15.25) - Provider Satisfaction Survey

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

(15.26) - Effectiveness of Quality Improvement Initiatives

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

(15.27) - 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 healthcare 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 healthcare 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 related grievances.

(15.28) - 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 Network 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

(15.29) - 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 the Illinois Department of Healthcare 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 (866) 800-1409 (VOICE), (888) 206-1327 (TTY) for victims aged 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 (800) 252-4343.

Reports of abuse, neglect and exploitation of Members residing in Supportive Living Facilities (SLF) should be made to the HFS SLF Complaint Hotline at (800) 226-0768.

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

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 16 - 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:

- Hospital Acquired Conditions and Present on Admission Program
- Claim Submission
- Coordination of Benefits (COB)/Third Party Liability (TPL)
- Medicaid Coverage for Molina Medicare Members
- Timely Claim Filing
• Claim Edit Process
• Claim Review
• Claim Auditing
• Corrected Claims
• Timely Claim Processing
• Electronic Claim Payment
• Overpayment and Incorrect Payment
• Claims Disputes/Reconsiderations
• Billing the Member
• Fraud and Abuse
• Encounter Data

(16.1) - Hospital-Acquired Conditions and Present on Admission Program

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

The following is a list of CMS Hospital Acquired Conditions. Effective October 1, 2008, CMS reduces payment for hospitalizations complicated by these categories of conditions that were not present on admission (POA):

• Foreign Object Retained After Surgery
• Air Embolism
• Blood Incompatibility
• Stage III and IV Pressure Ulcers
• Falls and Trauma
• Fractures
• Dislocations
• Intracranial Injuries
• Crushing Injuries
• Burn
• Other Injuries
• Manifestations of Poor Glycemic Control
• Hypoglycemic Coma
• Diabetic Ketoacidosis
• Non-Ketotic Hyperosmolar Coma
• Secondary Diabetes with Ketoacidosis
• Secondary Diabetes with Hyperosmolarity
• Catheter-Associated Urinary Tract Infection (UTI)
• Vascular Catheter-Associated Infection
• Surgical Site Infection Following Coronary Artery Bypass Graft – Mediastinitis
• Surgical Site Infection Following Certain Orthopedic Procedures:
  • Spine
  • Neck
  • Shoulder
  • Elbow
• Surgical Site Infection Following Bariatric Surgery Procedures for Obesity
• Laparoscopic Gastric Restrictive Surgery
• Laparoscopic Gastric Bypass
- Gastroenterostomy
- Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)
- Iatrogenic Pneumothorax with Venous Catheterization
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
- Total Knee Replacement
- Hip Replacement

**What this means to Providers:**

Acute IPPS Hospital claims will be returned with no payment if the POA indicator is coded incorrectly or missing; and

No additional payment will be made on IPPS hospital claims for conditions that are acquired during the patient’s hospitalization.

If you would like to find out more information regarding the Medicare HAC/POA program, including billing requirements, the following CMS site provides further information:

http://www.cms.hhs.gov/HospitalAcqCond/

**Claim Submission**

Participating providers are required to submit Claims to Molina with appropriate documentation. Providers must follow the appropriate State and CMS provider billing guidelines. Providers must utilize electronic billing though a clearinghouse or Molina’s Provider Portal, and use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims) and use electronic Payer ID number: 20934. For Members assigned to a delegated medical group/IPA that processes its own Claims, please verify the Claim Submission instructions on the Member’s Molina ID card.

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

**Required Elements**

The following information must be included on every claim:

- Member name, date of birth and Molina Member ID number.
- Member’s gender.
- Member’s address.
- Date(s) of service.
- Valid International Classification of Diseases diagnosis and procedure codes.
- Valid revenue, CPT or HCPCS for services or items provided.
- Valid Diagnosis Pointers.
- Total billed charges for service provided.
- Place and type of service code.
- Days or units as applicable.
- Provider tax identification.
- National Provider Identifier (NPI).
- Rendering provider as applicable.
- Provider name and billing address.
- Place of service and type (for facilities).
- Disclosure of any other health benefit plans.
• E-signature.
• Service Facility Location.

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

When an intern or a resident provides medical services to a participant, the teaching physician will be reimbursed. The teaching physician must: 1) be personally involved in the patient’s care; and 2) directly supervise the intern’s or resident’s activities. The employing hospital and/or teaching physician must maintain verification, which is readily available to Molina, that these requirements have been met. Such entries must be signed and dated by the physician seeking reimbursement. Signature stamps are not acceptable.

Exception: For residents beyond their first year, Molina will recognize the medical school’s or sponsoring hospital’s protocols in the department’s audit process if the protocol of each residency program meets all of the following: 1) identifies the level of supervision for each year of residency; 2) describes specific situations where residents may and may not function independently; and 3) specifies the manner in which documentation will be maintained to verify that the teaching physician has personally supervised the resident to the degree required in the protocol and has participated in the patient’s care to the degree specified in the protocol. Molina will accept the medical school’s or sponsoring hospital’s residency program supervision protocol and other medical record documentation in the determination of whether the teaching physician has provided appropriate supervision and assumed appropriate responsibility for the services provided by the resident. If the protocol and residency records are not readily available in the event of an audit, the medical school or sponsoring hospital will be held to the requirements specified in the first paragraph of this topic.

(16.5) - National Provider Identifier (NPI)

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

(16.6) - Electronic Claims Submission

Molina requires Participating providers to submit Claims electronically. Please reference the Provider Responsibilities section in this manual for information on electronic claims submissions.

(16.7) - Timely Claim Filing

Provider shall promptly submit to Molina Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina, and shall include any and all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina’s policies and procedures. Claims must be submitted by provider to Molina within 180 calendar days after the discharge for inpatient services or the Date of Service for outpatient services. If Molina is not the primary payer under coordination of benefits or third party liability, provider must submit Claims to Molina within 90 calendar days after final determination by the primary payer. Except as otherwise provided by Law or provided by Government Program requirements, any Claims that are not submitted to Molina within these timelines shall not be eligible for payment and provider hereby waives any right to payment.

(16.8) - Timely Filing of Claims for LTC Providers

Initial and corrected claims, despite retro eligibility changes, must be submitted within 180 days of the date of service or in accordance with the timeline in the provider’s Molina contract. Failure to submit these claims within the timely filing requirements will result in claim denial. LTC providers must NOT wait for the DHS and HFS approval of Members LTC benefits determination before submitting claims to Molina.
Please note: Providers must submit claims, within contract terms, receiving approval of LTC services as reimbursed by the Illinois Medical Assistance program. MCOs regularly receive official notification regarding Members who are approved for admission to LTC facilities. Notification includes information regarding the financial responsibility of Member on a monthly patient credit file (PCF). There can be delays in DHS notifying HFS of Members being approved for LTC services, therefore there are delays in receiving Member information (new or updated) on the HFS monthly PCF sent to Molina. The payor responsible for Member benefits, including all potential LTC benefits will be noted in MEDI for the applicable dates of service. Molina will readjudicate approved services when notified from HFS for any impacted claims received within timely filing guidelines.

Providers who receive a denial:

Providers who receive denials on claims for failing to meet timely filing requirements and want to dispute the denial must file a Claims Dispute Request Form within 90 days of the claim payment date. The dispute request written documents, such as proof of submission within the requirement timeframes. If the denial is due to Member not on the PCF, provider must file a ‘Claims dispute request form within 90 days of the claim payment date. Documentation provided includes that the claim was submitted within timely filing guidelines. MEDI screenshots will also be accepted as proof of HFS approved LTC benefits as long as documentation includes dates of service applicable to Member and facility information.

(16.9) - Fraud and Abuse

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

(16.10) - Timely Claim Processing

Claims processing will be completed for contracted providers in accordance with the timeliness provisions set forth in the provider’s contract. Unless the provider and Molina or contracted medical group/IPA have agreed in writing to an alternate schedule, Molina will process the claim for service within 30 days after receipt of Clean Claims.

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

(16.11) - Claim Editing Process

Molina 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.

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

COB

Medicaid is the payer 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 based on the state regulatory COB methodology. Primary carrier payment information is required with the Claim submission. Providers can submit Claims with attachments, including EOBs and other required documents, by utilizing Molina’s Provider Portal.

(16.13) - Third Party Liability

Molina Healthcare is the payer of last resort and will make every effort to determine the appropriate Third Party payer for services rendered. Molina Healthcare may deny Claims when Third Party has been established and will process 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.

(16.14) - Corrected Claims

Corrected Claims are considered new Claims for processing purposes. Corrected Claims must be submitted electronically with the appropriate fields on the 837I or 837P completed. Molina’s Provider Portal includes functionality to submit corrected Institutional and Professional claims. Corrected claims must include the correct coding to denote if the claim is Replacement of Prior Claim or Corrected Claim for an 837I or the correct Resubmission Code for an 837P.

(16.15) - EDI (Clearinghouse) Submission:

837P

In the 2300 Loop, the CLM segment (claim information) CLM05-3 (claim frequency type code) must indicate one of the following qualifier codes:

“1”-ORIGINAL (initial claim)

“7”-REPLACEMENT (replacement of prior claim)

“8”-VOID (void/cancel of prior claim)

In the 2300 Loop, the REF segment (claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN).

837I

Bill type for UB claims are billed in loop 2300/CLM05-1. In Bill Type for UB, the “1” “7” or “8” goes in the third digit for “frequency”.

In the 2300 Loop, the REF segment (claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN).

(16.16) - Claims Disputes and Adjustments

Providers seeking a redetermination of a claim previously adjudicated must request such action within 90 days of Molina’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 Claim Dispute/Adjustment and be sent to the following address:

Molina Healthcare of Illinois
Attention: Claim Dispute/Adjustments
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523
Fax: (855) 502-4962

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

The provider will be notified of Molina’s decision in writing within 60 calendar days of receipt of the Claim Dispute/Adjustment request. Providers may not “bill” the Member when a denial for covered services is upheld per review. A provider may request a claim redetermination when the claim was incorrectly denied as a duplicate or due to claims examiner or data-entry error.

(16.17) - Overpayment, Incorrect Payments and Refund Requests

If, as a result of retroactive review of coverage decisions or payment levels, Molina determines that it has made an Overpayment to a provider for services rendered to a Member, it will make a claim for such Overpayment.

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

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

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

• Providers contracted with Molina cannot bill the Member for any covered benefits. The provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.
• Providers agree that under no circumstance shall a Member be liable to the provider for any sums owed by Molina to the provider.
• Provider agrees to accept payment from Molina as payment in full, or bill the appropriate responsible party.
• Provider may not bill a Molina Member for any unpaid portion of the bill or for a claim that is not paid with the following exceptions:
• The Member has been advised by the provider that the service is not a covered benefit and the provider has documentation.
• The Member has been advised by the provider that he/she is not contracted with Molina and has documentation.
• The Member agrees in writing to have the service provided with full knowledge that they are financially responsible for payment.

(16.18) - Billing Members

Providers contracted with Molina cannot bill the Member for any covered benefits. The provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

• Providers agree that under no circumstance shall a Member be liable to the provider for any sums owed by Molina to the provider.
• Provider agrees to accept payment from Molina as payment in full, or bill the appropriate responsible party.
• Provider may not bill a Molina Member for any unpaid portion of the bill or for a claim that is not paid with the following exceptions:
• The Member has been advised by the provider that the service is not a covered benefit and the provider has documentation.
• The Member has been advised by the provider that he/she is not contracted with Molina and has documentation.
• The Member agrees in writing to have the service provided with full knowledge that they are financially responsible for payment.

(16.19) - Encounter Data

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

Encounter data must be submitted at least once per month, and within 30 days from the date of service in order to meet State and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I – 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 should be reported.

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

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

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

When your Encounters are filed electronically you should receive:

For any direct submission to Molina you should receive a 999 acknowledgement of your transmission

For Encounter submission you will also receive a 277CA response file for each transaction

(16.20) - Reimbursement Guidance
This information is intended to serve only as a general reference resource regarding Molina’s Healthcare, Inc. reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation.

Providers are responsible for submission of accurate claims. This Reimbursement Guidance is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided.

Coding of both diagnoses and procedures is required for all claims. The coding schemes acceptable by the Division are the International Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM for diagnoses and the CPT (Current Procedural Terminology) and HCPCS (The Healthcare Common Procedure Coding System) for procedures.

Molina Healthcare utilizes a claims adjudication system that encompasses edits and audits to facilitate the State and Federal requirements. The claims adjudication system’s exceptions used are based on nationally accepted standards, including but not limited to the American Medical Association’s CPT guidelines, National Correct Coding Initiative (NCCI) edits, Centers for Medicare and Medicaid Services (CMS) standards and publications, and other related medical literature and proprietary software.

(16.21) - National Correct Coding Initiative (NCCI)

The Centers for Medicare and Medicaid Services (CMS) has directed all Federal agencies to implement the National Correct Coding Initiative (NCCI) as policy in support of Section 6507 of the Patient Affordable Care Act of March 23, 2010. Molina Healthcare, Inc. uses NCCI standard payment methodologies.

NCCI Procedure to Procedure edits prevent inappropriate payment of services that should not be bundled or billed together and to promote correct coding practices. Based on NCCI Coding Manual and CPT guidelines, some services/procedures performed in conjunction with an evaluation and management (E&M) code will bundle into the procedure when performed by same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures. NCCI editing also includes Medically Unlikely Edits (MUEs) which prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

(16.22) - General Coding Requirements

Correct coding is required to properly process electronic and paper claims. The Plan requires that all claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

(16.23) - CPT and HCPCS Codes

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

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

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

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

(16.25) - **ICD-10-CM/PCS codes**

Effective 10/01/2015, Molina will utilize ICD-10-CM and PCS billing rules, and will deny claims that do not meet the Plan’s ICD-10 Claim Submission Guidelines. In order to ensure proper and timely reimbursement, codes must be effective on the dates of service (DOS) for which the procedure or service was rendered and not the date of submission. Refer to the ICD-10 CM/PCS Official Guidelines for Coding and Reporting on the proper assignment of principal and additional diagnosis codes.

Providers must submit ICD-10 codes for DOS or discharge on or after 10/01/2015. Claims containing ICD-9 codes for DOS on or after October 1, 2015, will be denied. Providers will be required to re-submit these claims with the appropriate ICD-10 code.

If an inpatient hospital claim spans 9/30 & 10/1 and has an admission and/or from date prior to 10/1/15, then the entire claim should be billed using ICD-10 codes.

The Plan will deny all claims that are billed with both ICD-9 and ICD-10 diagnosis codes on the same claim.

The Plan will only accept ICD-10 codes comprised of upper case characters. Any claim submitted with ICD-10 codes comprised of lower case characters will be denied.

(16.26) - **Place of Service Codes**

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

(16.27) - **Type of Bill**

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

(16.28) - Revenue Codes

Revenue codes are four-digit codes used to identify specific accommodation and/or ancillary charges. There are certain revenue codes that require CPT/HCPCS codes to be billed. For a complete list of codes, reference the National Uniform Billing Committee’s (NUBC’s) Official UB-04 Data Specifications Manual.

(16.29) - Diagnosis Related Group (DRG)

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

The Plan processes DRG claims through DRG software. If the submitted DRG and system-assigned DRG differ, the Plan-assigned DRG will take precedence. Providers may appeal with medical record documentation to support the ICD-10-CM principal and secondary diagnoses (if applicable) and/or the ICD-10-PCS procedure codes (if applicable). If the claim cannot be grouped due to insufficient information, it will be denied and returned for lack of sufficient information.

(16.30) - NDC

Effective May 1, 2014 the 11 digit National Drug Code Number (NDC) must be reported on all professional and outpatient claims when submitted on the CMS-1500 claim form, UB-04 or its electronic equivalent.

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

(16.31) - Coding Sources

(16.32) - Definitions

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

Category I Code – Procedures/Services

Category II Code – Performance Measurement

Category III Code – Emerging Technology

HCPCS – HealthCare Common Procedural Coding System; a Centers for Medicare and Medicaid Services (CMS) maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify procedure, supply and durable medical equipment codes furnished by physicians and other health care professionals.

ICD-10-CM – International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM diagnosis codes are maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).
ICD-10-PCS - International Classification of Diseases, 10th revision, Procedure Coding System used to report procedures for inpatient hospital services.

(16.33) - Claim Auditing

Provider acknowledges Molina’s right to conduct post-payment billing audits. Provider shall cooperate with Molina’s audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical records, provider’s charging policies, and other related data. Molina shall use established industry Claims adjudication and/or clinical practices, State, and Federal guidelines, and/or Molina’s policies and data to determine the appropriateness of the billing, coding, and payment.

(16.34) - Electronic Claim Payment

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

Section 17 – Hospitals

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

(17.1) - 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.

Members accessing the emergency department inappropriately will be contacted by Molina 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.

(17.2) - Admissions

Hospitals are required to notify Molina within 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.

(17.3) - Claims Submission

Claims must be submitted in accordance with the guidelines and processes set forth in Section 10 (Claims) of this manual. Additional detailed billing guidelines are located on the Molina website under Communications.

(17.4) - Value Code 54 for Birth Weight

Hospitals are required to enter Value Code 54 on claims for all newborns who are 14 days of age or less on the date of admission. This Value Code is to be reported with the baby’s birth weight in grams, right-justified to
the left of the dollar/cents delimiter, and will be used in the APR-DRG determination. Claims that do not have this value reported will be rejected.

On the paper UB-04, Value Code 54 should be reported in block 39, 40 or 41. Decimal points should be used to report the weight. For example, if the birth weight is 1000 grams, the weight should be reported as 1000.00 along with Value Code 54.

For 837i electronic claims, birth weight is reported in 2300 Loop, HI01-05 (Monetary Amount) where HI01-02 (Industry Code) = 54. Monetary Amount is translated to whole numbers. For example, $2106.00 should read as 2106 grams.

The diagnosis coded on the claim must be consistent with the reported baby weight.

(17.5) - MCO Hospital Access Program

The Illinois General Assembly has determined and authorized certain payments to preserve and improve access to hospital services for Medicaid enrollees, including hospital access payments authorized under Sections 12.2 and 12.4 of Article V-A of the Illinois Public Aid Code. Furthermore, Public Act 96-851 states that a portion of the access payments for hospitals, including those authorized under Article V-A, will be used to increase the capitation payment rates paid to MCOs for hospital services beginning in the state fiscal year 2015.

Section 18 – Fraud, Waste and Abuse

Introduction

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

(18.1) - Mission Statement

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

(18.2) - 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:
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.

(18.3) - 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.

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

- The Federal False Claims Act and state laws pertaining to submitting false claims;
- How providers will detect and prevent fraud, waste, and abuse;
- Employee protection rights as 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 disclosing or reporting a false claim are entitled to all relief necessary to make the employee whole including:

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

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

(18.4) - Definitions of Fraud, Waste and Abuse

**Fraud:**

“Fraud” means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR § 455.2)
**Waste:**

Health care spending that can be eliminated without reducing the quality of care. Quality Waste includes, overuse, underuse, and ineffective use. Inefficiency Waste includes redundancy, delays, and unnecessary process complexity. 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) causes unnecessary costs to the Medicaid program.

**Abuse:**

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

(18.5) - Examples of Fraud, Waste and Abuse by a Provider

- Billing for services, procedures and/or supplies that have not actually been rendered.
- Providing services to patients that are not medically necessary.
- Balance Billing a Medicaid Member for Medicaid covered services. For example, asking the patient to pay the difference between the discounted fees, negotiated fees, and the provider’s usual and customary fees.
- Intentional misrepresentation or 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 identification card. Failure to report a patient’s forgery/alteration of a prescription. Knowingly and willfully soliciting/receiving payment of kickbacks or bribes in exchange for the referral of Medicaid patients.
- A physician knowingly and willfully referring Medicaid patients to health care facilities in which or with which the physician has a financial relationship. (The Stark Law)

(18.6) - Review of Provider
The Central Credentialing Department is responsible for monitoring practitioners through the various government reports, including:

- Federal and State Medicaid sanction reports.
- Federal and state lists of excluded individuals and entities including the state of Illinois exclusion list
- List of parties excluded from Federal Procurement and Non-procurement Programs. Medicaid suspended and ineligible provider list.
- Monthly review of state Medical Board sanctions list.
- 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 Credentialing Committee for review and potential action. The Credentialing 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.

(18.7) - Provider/Practitioner Education

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

The Molina Provider Network Management Representative will inform the provider’s office that an on-site meeting is required in order to educate the provider on certain issues identified as inappropriate or deficient.

(18.8) - Review of Provider Claims and Claims System

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

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

(18.9) - Reporting Fraud, Waste and Abuse

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

Molina AlertLine can be reached toll free at 1-866-606-3889 or you may use the service’s website to make a report at any time at https://molinahealthcare.alertline.com.
You may also report cases of fraud, waste or abuse to the Molina Compliance Department. You have the right to have your concerns reported anonymously without fear of retaliation.

(18.10) - 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

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](http://www.state.il.us/agency/oig/reportfraud.asp)

Section 19 - Credentialing and Recredentialing

In accordance with 42 CFR 438.214, provider enrollment in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system constitutes Illinois’ Medicaid managed care uniform credentialing and re-credentialing process. To participate in Molina’s provider network, providers must be enrolled in IMPACT.

Molina is prohibited from requiring providers to undergo additional credentialing processes. It is the objective of Molina to provide superior health care to the community.

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.

(19.1) - Definitions

A Rental/Leased Network - a network of providers that leases its panel to another network or insurer with an emphasis on expanding provider access and negotiating discounted fee-for-service fees. This type of network is sometimes referred to as a brokerage-leased network or thought of as “wholesale,” since Members’ access to the network is through an intermediary.

Primary Care Provider (PCP) – a provider who has the responsibility 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 Providers, General Providers or Internists, as designated by Molina.
General Practitioner – Physicians who are not Board Certified and have not completed a training program from an accredited training program in their requested specialty.

Urgent Care Provider (UCP) - a provider who is not a PCP and only provides urgent care services to Members. Urgent care services are medically necessary services, which are required for an illness or injury that would not result in further disability or death if not treated immediately, but require professional attention and have the potential to develop such a threat if treatment is delayed longer than 24 hours. A UCP may include PA, NP, MD and DO. The UCP is usually trained in general practice, internal medicine, family medicine, pediatrics, or emergency medicine. Some UCPs may also have specialty training.

Primary Source verification - the process by which Molina verifies credentialing information directly from the entity that originally conferred or issued the credential to the provider.

Locum Tenens – a substitute physician used to fill in for a regular physician for reasons such as illness, pregnancy, vacation, or continuing medical education. The regular physician bills and receives payment for the substitute physician as though he/she performed them. The substitute physician generally has no practice of his/her own and moves from area to area as needed. The regular physician generally pays the substitute physician a fixed amount per diem, with the substitute physician having the status of an independent contractor rather than an employee.

Physician – is a Doctor of Medicine (MD) or Doctor of Osteopathy (DO)

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.

(19.2) - Criteria for Participation in the Molina Network

Molina will verify that providers are enrolled in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) for the evaluation and selection of providers for participation in the Molina network. To remain eligible for participation providers must continue to satisfy all applicable requirements as it relates to enrollment in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) for participation.

Molina reserves the right to exercise discretion in applying any criteria and to exclude providers who do not meet the criteria. Molina may, after considering the recommendations of the Credentialing Committee, waive any of the requirements for network participation established pursuant to these policies for good cause if it is determined such waiver is necessary to meet the needs of Molina and the community it serves. The refusal of Molina to waive any requirement shall not entitle any provider to a hearing or any other rights of review.

(19.3) - Burden of Proof

The provider shall have the burden of producing adequate information to prove he/she meets all criteria for initial participation and continued participation in the Molina network. The provider must maintain enrollment in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT). This includes, but is not limited, to proper evaluation of their experience, background, training, demonstrated ability and ability to perform as a provider 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 network. If the provider fails to maintain enrollment in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) it will result in an administrative denial or termination from the Molina network. Providers who fail to provide this burden of proof do not have the right to submit an appeal.
(19.4) - Provider Termination and Reinstatement

If a provider’s contract is terminated and later it is determined to reinstate the provider, the provider must be enrolled in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) if there is a break in service more than thirty (30) calendar days.

(19.5) - Providers Terminating with a Delegate and Contracting with Molina Directly

Providers credentialed by a delegate who terminates their contract with the delegate and either have an existing contract with Molina or wish to contract with Molina directly must enroll with IMPACT within six (6) months of the provider’s termination with the delegate. If the provider has a break in service more than thirty (30) calendar days, the provider must be enrolled with IMPACT prior to reinstatement.

(19.6) - Credentialing Application

In accordance with 42 CFR 438.214, provider enrollment in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system constitutes Illinois’ Medicaid managed care uniform credentialing and re-credentialing process. To participate in contractor’s provider network, contractor must verify that provider is enrolled in IMPACT.

(19.7) - The Process for Making Credentialing Decisions

Providers requesting participation within the Molina network must be enrolled in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT).

(19.8) - Process for Delegating Credentialing and Recredentialing

Molina will delegate credentialing and recredentialing activities to Independent Practice Associations (IPA) and Provider Groups that meet Molina’s requirements for delegation. Molina’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’s requirements.

Molina’s Credentialing Committee retains the right to approve new providers and provider sites and terminate providers, providers and sites of care based on requirements in the Molina 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’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 percent.
- Correct deficiencies within mutually agreed upon time frames when issues of non-compliance are identified by Molina at pre-assessment.
- Agree to Molina’s contract terms and conditions for credentialing delegates.
- Submit timely and complete reports to Molina as described in policy and procedure.
- Comply with all applicable federal and state Laws.
- If the IPA or Provider Group sub-delegates primary source verification to a Credentialing Verification Organization (CVO), the CVO must be NCQA© certified in all ten areas of accreditation.

(19.9) - Non-Discriminatory Network Participation

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

(19.10) - Prevention

Molina maintains a heterogeneous credentialing committee Membership. It is also required that each committee Member signs an affirmative statement annually to make decisions in a nondiscriminatory manner.

(19.11) - Confidentiality and Immunity

Information regarding any provider or provider submitted, collected, or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care shall, to the fullest extent permitted by Law, be confidential and shall only be disseminated to a Representative in order to carry out appropriate activities under this Policy and Procedure. Confidentiality shall also extend to such information that is provided by third parties.

For purposes of this section a “Representative” shall mean any individual authorized to perform specific information gathering or disseminating functions for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care.

For purposes of this section “information” may be any written or oral disclosures including, but not limited to, a provider’s or provider’s professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care or provider’s provision of patient care services.

By providing patient care services at Molina, a provider:

- Authorizes representatives of Molina to solicit, provide, and act upon information bearing on the provider’s qualifications.
- Agrees to be bound by the provisions of this policy and procedure and to waive all legal Claims against any representative who acts in accordance with the provisions of this policy and procedure.
- Acknowledges that the provisions of this policy and procedure are express conditions of the application for, or acceptance of, Molina Membership and the continuation of such membership, and to the exercise of clinical privileges or provision of patient care.

The confidentiality and immunity provisions of this policy and procedure shall apply to all information so protected by State or Federal Law. To the fullest extent permitted by State or Federal Law, the confidentiality and immunity provisions of this policy and procedure shall include, but is not limited to:

- Any type of application or reapplication received by the provider;
- Actions reducing, suspending, terminating or revoking a provider’s status, including requests for corrective actions, investigation reports and documents and all other information related to such action;
- Hearing and appellate review;
- Peer review and utilization and quality management activities;
- Risk management activities and Claims review;
- Potential or actual liability exposure issues;
- Incident and/or investigative reports;
- Claims review;
- Minutes of all meetings by any committees otherwise appropriately appointed by the Board;
- Any activities related to monitoring the quality, appropriateness or safety of health care services;
- Minutes of any Committees and Subcommittees related to monitoring the quality, appropriateness or safety of health care services;
- Any Molina operations and actions relating to provider conduct.

(19.12) - Immunity from Liability for Action Taken:

No representative shall be liable to a provider or any third party for damages or other relief for any decision, opinion, action, statement, or recommendations made within the scope of their duties as representative, if such representative acts in good faith and without malice.

(19.13) - Immunity from Liability for Providing Information:

No representative or third parties shall be liable to a provider for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative or to any third party pursuant to authorization by the provider, or if permitted or required by; Law, or these Policies and Procedures, provided that such representative or third parties acts in good faith and without malice.

(19.14) - Cumulative Effect:

The provisions in this Policy and Procedure and any forms relating to authorizations, confidentiality of information, and immunities from liability are in addition to other protections provided by relevant state and federal Law, and are not a limitation thereof.

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.

The Director in charge of Credentialing grants access to electronic credentials files 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. Each person is given a unique user ID and password. It is the strict policy of Molina 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-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 staff is instructed not to divulge passwords to their co-workers.

(19.15) - Providers Rights during the Credentialing Process

Providers may contact HFS in regards to any issues regarding their enrollment in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT). Providers can contact HFS as follows:

| Providers with **general questions about IMPACT or provider enrollment** should contact: |
| Email: IMPACT.Help@Illinois.gov |
| Phone: 1-877-782-5565 (select option #1) |
| Providers that are **having trouble logging in** to the IMPACT system should contact: |

(19.16) - Credentialing Committee

Molina designates a Credentialing Committee to make recommendations regarding decisions using a peer review process. Molina works with the Credentialing Committee to strive to assure that network providers are competent and qualified to provide continuous quality care to Molina Members.

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 providers, 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 provider for damages or other relief for any action taken or statements or recommendations made within the scope of the committee duties exercised.

(19.17) - 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.

Pursuant to section 1128 of the SSA, Molina and its subcontractors may not subcontract with an excluded provider/person. Molina and its subcontractors shall terminate subcontracts immediately when Molina and its subcontractors become aware of such excluded provider/person or when Molina and its subcontractors receive notice. Molina and its subcontractors certify that neither it nor its Member/provider 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 and its subcontractors are unable to certify any of the statements in this certification, Molina and its subcontractors shall attach a written explanation to this agreement.

(19.18) - Ongoing Monitoring of Sanctions

Molina Central Credentialing monitors provider sanctions for all provider types and takes appropriate action against providers when occurrences of poor quality is identified.

(19.19) - Medicare and Medicaid Sanctions and Exclusions

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 thirty (30) calendar days of its release, Molina reviews the report to identify if any Molina provider is found with a sanction. If a Molina provider is found to be sanctioned by the OIG the provider's contract will immediately be terminated effective the same date the sanction was implemented.
Molina also monitors each state Medicaid sanctions/exclusions/terminations through each state’s specific Program Integrity Unit (or equivalent). Molina reviews each state’s published report within thirty (30) days of its release to identify if any Molina provider is found to be sanctioned/excluded/terminated from any state’s Medicaid program. If a Molina provider is found to be sanctioned/excluded/terminated, the provider will be immediately terminated in every state where they are contracted with Molina and for every line of business.

(19.20) - Sanctions or Limitations on Licensure

Molina monitors for sanctions or limitations against licensure for its network providers. Sanction or limitation of license information discovered during the ongoing monitoring process will be maintained in the provider file. Providers with identified sanctions or limitations on license in the ongoing monitoring process will be immediately terminated.

(19.21) - NPDB Continuous Query

Molina enrolls its network providers with the National Practitioner Data Bank (“NPDB”) Continuous Query service. Once providers are enrolled in the Continuous Query Service, Molina will receive instant notification of all new NPDB reports against the enrolled providers. When a new report is received, the provider will be immediately reviewed for enrollment within Molina’s provider network.

(19.22) - Member Complaints/Grievances

Each Molina Health Plan has a process in place to investigate provider-specific complaints from Members upon their receipt. Molina evaluates both the specific complaint and the provider’s history of issues, if applicable. The history of complaints is evaluated for all providers at least every six months.

Each Molina Health Plan has a process in place for monitoring provider adverse events at least every six months. An adverse event is an injury that occurs while a Member is receiving health care services from a provider. Molina monitors for adverse events at least every six months.

(19.23) - Medicare Opt-Out

Providers participating in Medicare must not be listed on the Medicare Opt-Out report. Molina reviews the Opt-Out reports released from the appropriate Medicare financial intermediary showing all of the providers who have chosen to Opt-Out of Medicare. These reports are reviewed within thirty (30) calendar days of their release. If a provider opts out of Medicare, that provider may not accept Federal reimbursement for a period of two (2) years. These provider contracts will be immediately terminated for the Molina Medicare line of business.

(19.24) - Social Security Administration (SSA) Death Master File

Molina screens provider names against the SSA Death Master File database as part of an ongoing monitoring process. The names are also screened on a monthly basis to ensure there are no matches on the SSA Death Master File. If Molina identifies an exact match, the provider will be immediately terminated for all lines of business effective the deceased date listed on the SSA Death Master File database.

(19.25) - System for Award Management (SAM)

Molina monitors the SAM once per month to ensure providers have not been sanctioned. If a Molina provider is found with a sanction, the provider’s contract is immediately terminated effective the same date the sanction was implemented.
(19.26) - Program Integrity (Disclosure of Ownership/Controlling Interest)

Medicaid Managed Care health plans are required to collect specific information from network providers prior to contracting to ensure that it complies with federal regulations that require monitoring of federal and state sanctions and exclusions databases. This monitoring ensures that any network providers and the following details of any individual/entity being contracted and those individuals/entities affiliated with the contractor are appropriately screened against these sources, ensuring compliance with Social Security Act (SSA) section 1903(i)(2) of the Act; 42 CFR 455.104, 42 CFR 455.106, and 42 CFR 1001.1901(b). The categorical details required and collected are as follows:

Molina requires a current and complete Disclosure of Ownership and Control Interest Form. Molina screens all individual names and entities listed on the form against the OIG, SAM, Medicare Opt-Out and each state’s specific Program Integrity Unit databases. These individual names and entities are also screened monthly for any currently sanctioned/excluded/terminated individuals or entities. Molina will not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity. This monitoring ensures that any individual/entity being contracted and those individuals/entities affiliated with the contractor are appropriately screened against federal and state agency sources, ensuring compliance with 42 CFR §455.

Molina requires the Disclosure of Ownership and Control Interest Form be reviewed and re-attested to every thirty-six (36) months to ensure the information is correct and current.

Molina screens the entire contracted provider network against the OIG, SAM, Medicare Opt-Out, each state’s specific Program Integrity Unit and Social Security Death Master File databases for any currently sanctioned/excluded/terminated individuals or entities. Molina will not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity.

Molina will immediately recover any payments for goods and services that benefit excluded individuals and entities that it discovers. Molina will immediately terminate any employment, contractual and control relationships with an excluded individual and entity that it discovers.

If a state specific Program Integrity Unit notifies Molina an individual or entity is excluded from participation in Medicaid, Molina will terminate all beneficial, employment, and contractual and control relationships with the excluded individual or entity immediately.

(19.27) - Range of Actions, Notification to Authorities and Provider Appeal Rights

Molina uses established criteria in the review of providers’ 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.

(19.28) - Range of actions available

The Molina Credentialing Committee can take one of the following actions against providers 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 provider may be summarily suspended from participation in the network, without prior notice, pending review and investigation of information relevant to the case.

(19.29) - 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 provider from the Molina network include, but are not limited to, the following:

- The provider's professional license in any state has or 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.
- Provider has or 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 provider's acts, omissions or conduct.
- Provider 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 provider to Molina Members.
- Provider has or has ever had any restrictions, probations, limitations, conditions, suspensions or revocations on their federal Drug Enforcement Agency (DEA) certificate or Registration.
- Provider 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 provider has an alcohol, chemical dependency problem or health condition and there is no clear evidence and documentation demonstrating that the provider 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 provider’s practice.
- Provider has or 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.
- Provider has or has ever had any denials, limitations, suspensions or terminations of participation of privileges or surrendered privileges while under investigation by any health care institution, plan, facility or clinic.
- Provider’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.
- Provider has a criminal history, including, but not limited to, any criminal charges, criminal investigations, convictions, no-contest pleas and guilty pleas.
- Provider has or has ever had involvement in acts of dishonesty, fraud, deceit or misrepresentation that relate to or impact or could relate to or impact the provider's professional conduct or the health, safety or welfare of Molina Members.
- Provider has or has ever engaged in acts which Molina, in its sole discretion, deems inappropriate.
- Provider has or has ever had a pattern of Member complaints or grievances in which there appears to be a concern regarding the quality of service provided to Molina Members.
- Provider has not complied with Molina’s quality assurance program.
- Provider is found to have rendered a pattern of substandard care or is responsible for any gross or flagrant incident of substandard care.
- Provider has or has ever displayed inappropriate patterns of referral, which deviate substantially from reasonably expected patterns of referral.
- Provider makes or has ever made any material misstatements in or omissions from their credentialing application and attachments.
• Provider has ever rendered services outside the scope of their license.
• Provider has or has ever had 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.
• Provider has or has ever failed to comply with the Molina Medical Record Review Guidelines.
• Provider has or has ever failed to comply with the Molina Site Review or Medical Record Keeping Practice Review Guidelines.

(19.30) - Monitoring Providers Approved on a ‘Watch Status’ by the Committee

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

When a provider 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 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 recommendation.

(19.31) - Corrective Action

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

Within ten (10) calendar days of the Credentialing Committee’s decision to place provider on a corrective action plan, the provider will be notified via a certified letter from the Medical Director. Such notification will outline:

• The reason for the corrective action
• The corrective action plan

If the corrective actions are resolved, the provider'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 provider continue on an improvement plan, or recommend suspension or termination. All recommendations for termination that result from a lack of appropriate provider response to corrective action will be brought to the Credentialing Committee for review and decision.

(19.32) - Summary Suspension

In cases where the Credentialing Committee or the Medical Director becomes aware of circumstances that pose an immediate risk to patients, the provider 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 provider of the suspension by written notification sent via certified letter. Notification will include the following:

• A description of 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 provider.

The length of the suspension.

The estimated timeline for determining whether or not to reinstate or terminate the provider.

Details regarding the provider’s right to request a fair hearing within thirty (30) calendar days of receipt of the notice and their right to be represented by an attorney or another person of their choice (see Fair Hearing Plan policy).

If the provider does not request a fair hearing within the thirty (30) calendar days, they have waived their rights to a hearing.

The action will be reported to the NPDB if the suspension is in place longer than thirty (30) calendar days.

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 provider’s continued participation, discontinue the suspension or terminate the provider.

(19.33) - Reporting to Appropriate Authorities

Molina will make reports to appropriate authorities as specified in the Molina Fair Hearing Plan Policy when the Credentialing Committee takes or recommends certain Adverse Actions for a provider based upon Unprofessional Conduct or quality of care. Adverse Actions include:

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

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

- All appropriate state licensing agencies
- National Practitioner Data Bank (NPDB)

A letter is then written to the appropriate state licensing boards describing the adverse action taken, the provider it was taken against and a copy of the NPDB report is attached to the letter. This letter is sent certified to the appropriate state licensing boards within 24-hours of receiving the final NPDB report. A copy of this letter is filed into the provider’s credentials file. The action is also reported to other applicable State entities as required.

(19.34) - 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 and the National Practitioner Data Bank (NPDB).

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 and the NPDB.

(19.35) - 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:
Revocation, termination of, or expulsion from Molina provider status when such revocation, termination, or expulsion is reportable to the State Licensing Board and the NPDB.

Suspension, reduction, limitation, or revocation of authority to provide care to Molina Members when such suspension, reduction, limitation, or revocation is reportable to the State Licensing Board and the NPDB.

Any other final action by Molina that by its nature is reportable to the State Licensing Board and the NPDB.

(19.36) - 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:

- State the reasons for the action;
- State any Credentialing Policy provisions that have been violated;
- Advise the provider that he/she has the right to request a hearing on the proposed Adverse Action;
- 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 Plan Medical Director by certified mail, return receipt requested, or personal delivery;
- Advise the provider that he/she has the right to be represented by an attorney or another person of their choice.
- 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;
- State that the proposed action or recommendation, if adopted, must be reported pursuant to State and Federal Law; and
- Provide a summary of the provider’s hearing rights or attach a copy of this Policy.

(19.37) - Request for a Hearing – Waiver

If the Provider does not request a hearing in writing to the Chief Medical Officer 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 Chief Medical Officer 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.

(19.38) - Appointment of a Hearing Committee

(19.39) - Composition of Hearing Committee

The Chief Medical Officer/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.

(19.40) - 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.

(19.41) - Responsibilities

The Hearing Committee shall:

- Evaluate evidence and testimony presented.
- Issue a decision accepting, rejecting, or modifying the decision of the Peer Review Committee and/or Credentialing Committee.
- Maintain the privacy of the hearing unless the Law provides to the contrary.

(19.42) - 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.

(19.43) - Disclosure and Challenge Procedures

Any person appointed to the Hearing Committee shall disclose to the Chief Medical Officer/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.

(19.44) - Time and Place of Hearing

Upon receipt of a Request for Hearing, the Chief Medical Officer and/or Plan President shall schedule and arrange for a hearing. The Chief Medical Officer 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.

(19.45) - Pre-Hearing Procedures

The Provider shall have the following pre-hearing rights:

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

- To inspect and copy, at Molina’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.

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:

- Whether the information sought may be introduced to support or defend the charges;
- The exculpatory or inculpatory nature of the information sought, if any;
- The burden attendant upon the party in possession of the information sought if access is granted; and
- Any previous requests for access to information submitted or resisted by the parties.

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.

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.

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.

(19.46) - Conduct of Hearing

(19.47) - 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:

- Call and examine witnesses for relevant testimony.
- Introduce relevant exhibits or other documents.
- Cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues.
- Otherwise rebut evidence.
- Have a record made of the proceedings.
- Submit a written statement at the close of the hearing.
- 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.

(19.48) - Course of the Hearing

- Each party may make an oral opening statement.
- The Peer Review Committee and/or Credentialing Committee shall call any witnesses and present relevant documentary evidence to support its recommendation.
• The affected Provider may then call any witnesses and present relevant documentary evidence supporting his/her defense.
• 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.
• 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.

(19.49) - Use of Exhibits

• Exhibits, when offered by either party, may be received into evidence by the Hearing Committee as ruled upon by the Hearing Officer.
• A description of the exhibits in the order received shall be made a part of the record.

(19.50) - Witnesses

• Witnesses for each party shall submit to questions or other examination.
• 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.
• 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.
• The party producing such witnesses shall pay the expenses of their witnesses.

(19.51) - Rules for Hearing:

(19.52) - 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.

(19.53) - 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.

(19.54) - Interpreter

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

(19.55) - 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:

- A summary of facts and circumstances giving rise to the hearing.
- A description of the hearing, including:
  - The panel members’ names and specialties;
  - The Hearing officer’s name;
  - The date of the hearing;
  - The charges at issue; and
- An overview of witnesses heard and evidence.
- The findings and recommendations of the Hearing Committee.
- 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.

(19.56) - 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 his/her 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.

(19.57) - 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.

(19.58) - 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, 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.

(19.59) - 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.
(19.60) - Postponements

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

(19.61) - 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.

(19.62) - Final Decision

Upon receipt of the Hearing Committee’s decision, the Chief Medical Officer/Plan President shall either adopt or reject the Hearing Committee’s decision. The Chief Medical Officer/Plan President’s action constitutes the final decision.

(19.63) - Reporting

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

Reports to the State Licensing Board and the NPDB for adverse actions must be submitted within 15 days from the date the adverse action was taken.

(19.64) - 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.

(19.65) - Confidentiality and Immunity

Information regarding any Provider submitted, collected, or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care shall, to the fullest extent permitted by Law, be confidential and shall only be disseminated to a Representative in order to carry out appropriate activities under these Policies and Procedures. Confidentiality shall also extend to such information that is provided by third parties.

For purposes of this section a “Representative” shall mean any individual authorized to preform specific information gathering or disseminating functions for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care.

For purposes of this section “information” may be any written or oral disclosures including, but not limited to, a Provider’s professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care or Provider’s provision of patient care services.

(19.66) - By providing patient care services at Molina, a Provider:

- Authorizes representatives of Molina to solicit, provide, and act upon information bearing on the Provider’s qualifications.
• Agrees to be bound by the provisions of this policy and procedure and to waive all legal claims against any representative who acts in accordance with the provisions of this policy and procedure.
• Acknowledges that the provisions of this policy and procedure are express conditions of the application for, or acceptance of, Molina Membership and the continuation of such membership, and to the exercise of clinical privileges or provision of Patient care.

The confidentiality and immunity provisions of this policy and procedure shall apply to all information so protected by State or Federal Law. To the fullest extent permitted by State or Federal Law, the confidentiality and immunity provisions of this policy and procedure shall include, but is not limited to:

Any type of application or reapplication received by the Provider;

Actions reducing, suspending, terminating or revoking a Provider’s status, including requests for corrective actions, investigation reports and documents and all other information related to such action;

• Hearing and appellate review;
• Peer review and utilization and quality management activities;
• Risk management activities and Claims review;
• Potential or actual liability exposure issues;
• Incident and/or investigative reports;
• Claims review;
• Minutes of all meetings by any committees otherwise appropriately appointed by the Board;
• Any activities related to monitoring the quality, appropriateness or safety of health care services;
• Minutes of any Committees and Subcommittees related to monitoring the quality, appropriateness or safety of health care services;
• Any Molina operations and actions relating to Provider conduct.

Immunity from Liability for Action Taken: No representative shall be liable to a Provider or any third party for damages or other relief for any decision, opinion, action, statement, or recommendations made within the scope of their duties as representative, if such representative acts in good faith and without malice.

Immunity from Liability for Providing Information: No representative or third parties shall be liable to a Provider for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative or to any third party pursuant to authorization by the Provider, or if permitted or required by Law, or these Policies and Procedures, provided that such representative or third parties acts in good faith and without malice.

Cumulative Effect: The provisions in this Policy and Procedure and any forms relating to authorizations, confidentiality of information, and immunities from liability are in addition to other protections provided by relevant state and federal Law, and are not a limitation thereof.

**Section 20 – Provider Inquiries**

Providers may inquire on a claim denial on their behalf in accordance with Molina policy. Molina contracted providers have the right to request a reconsideration of a denial, referral, modification, or termination of health care services. Providers also have the right to file a written complaint.

**(20.1) - Provider Inquiry Process**

A request to review the processing, payment or non-payment of a claim by Molina shall be classified as a Provider Inquiry and shall be sent to the following address:

Molina Healthcare of Illinois
A contracted provider may dispute a claim or utilization denial on his or her behalf by faxing or mailing a completed Claims Reconsideration Request Form and/or a letter of reconsideration with supporting documentation as appropriate. The Claims Reconsideration Request Form must be completed to document the review request. The Claim Reconsideration Request Form is located online at www.MolinaHealthCare.com for providers by utilizing the “Forms” link.

All provider disputes for payment or non-payment must be submitted to Molina within 90 calendar days of date of original remittance advice. All requests received after this timeframe will be denied for untimely filing. An upheld resolution letter will be sent to the provider. The provider may submit documentation proving timely filing if the provider believes that they have filed the request within in the appropriate timeframe. The only acceptable proof of timely filing is a registered postal or similar receipt from another commercial delivery system signed by Molina staff.

Molina will have sixty (60) calendar days to process a claims related dispute or reconsideration request. All requests submitted without appropriate documentation will be denied for lack of information. The provider will be responsible for providing the appropriate requested documentation within 30 days business from the date of the request. Any documentation received after the 30-day timeframe will not be reviewed and the case will be closed. Member information or medical records must be submitted at the request of Molina or regulatory agency reviews as required. The provider shall not charge the Member or Molina for medical record copies when submitted for this review purpose.

(20.2) - Provider Complaints

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

Molina Healthcare of Illinois, Inc.
Attn: Provider Complaints Dept.
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523
Or
Via Fax: (855) 502-4962

(20.3) - Member Appeals Processes

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

Below are Molina’s Enrollees Appeals Process.

Appeals may be submitted by Enrollees or an authorized representative, such as a family Member or their provider in response to an Adverse Benefit Determination. If Molina’s decision is to deny a service in whole or part, Members and providers are notified of the following at the time of denial:

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

(20.4) - Type of Appeals

An Enrollee may request an expedited appeal, or standard appeal. Standard appeals may be filed orally or in writing and are requesting a to change an adverse determination for care or services submitted by the enrollee or their authorized representative within sixty (60) days from the Adverse Benefit Determination notice.

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

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

(20.5) - Member Authorized Representative

An Enrollee may appoint an Authorized Representative to act on their behalf. The representative may be a guardian, caretaker, relative, health care provider, or an attorney. Any standard appeals requested on behalf of the Member, must have the written authorization from the Member. The Member is required to complete an Authorized Representative Designation Form and send the form to Molina with the appeal request. Molina can provide the form as needed.

An Authorized Representative Designation Form must be completed and signed by the Member within 15 days of the receipt of the appeal. Lack of written consent does not pose any barrier to the Member’s appeal process; however, if it is not received within the timeframe, the appeal request will be closed and the Member will be notified that the appeal was closed with no determination as the authorization form was not received.

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

(20.6) - Standard Appeals Process and Timeline

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

Molina Healthcare of Illinois, Inc.
Attn: Appeals and Grievance  
1520 Kensington Rd., Suite 212  
Oak Brook, IL 60523  
Or  
Via Fax: (855) 502-5128

All appeal requests must include the Enrollee’s name, address, Enrollee’s number, reasons for appealing, and documentation or evidence such as medical records, physician letters, or other important information that explains the reason the service or item is needed. An Authorized Representative Form should be attached to the request when appropriate on behalf of a Member. An appeal request submitted after the 60-day timeframe must provide good cause in order for Molina to consider the late request such as, the Member being seriously ill preventing the ability to file the appeal.

Upon receipt of an appeal, Molina will notify the party filing the appeal, of all information that is required to evaluate the appeal. A written acknowledgement will be sent to the Member within three business days of receipt of the request.

Molina will render a decision on the appeal within 15 business days after receipt of the appeal request. Molina will notify the party filing the appeal, the Member (or authorized representative) the Member’s PCP, and any health care provider who recommended the 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’s determination, an External Independent Review or a State Medicaid hearing may be requested. No one reviewing an appeal may have had any involvement in the initial determination that is the subject of the appeal.

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

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

Enrollees who are not satisfied with Molina’s resolution of any appeal may request a State Hearing with the Illinois Department of Healthcare and Family Services (HFS) at the following location if they are part of the Health Choice of Illinois.

Illinois Department of Healthcare and Family Services  
Bureau of Administrative Hearing  
69 W. Washington, 4th Floor.  
Chicago, IL 60602  
Fax: (312) 793-2005  
Or you may call (855) 418-4421  
For hearing impaired, TTY at (800) 526-5812

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

Enrollees who are not satisfied with Molina’s resolution of an appeal may request a State Hearing with the Illinois Department of Human Services (DHS) at the following location if the Members are part of the Persons with Disabilities, Persons with Traumatic Brain Injury (TBI), or Persons with HIV/AIDS waiver populations contained within Health Choice of Illinois Service Package II:
(20.7) - Expedited Internal Appeals Process and Timeline

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

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

Molina will render a decision within twenty-four (24) hours after receiving the required information. If additional information required to make the final appeal determination is not received within seventy-two (72) hours, a determination will be made with the current information available.

A denial of an expedited portion of the appeal will result in Molina automatically processing the appeal as a standard appeal. The fifteen (15) business day timeframe from the date the request was received will be initiated.

Molina will notify the party filing the appeal, the Enrollee (or designated representative) the Enrollee’s PCP, the requesting provider, and any health care provider who recommended the service involved in the appeal orally of its decision. Oral notification will be followed up by a written notice of determination within two (2) calendar days following the oral notification.

(20.8) - External Independent Review

An external independent review may be requested by a non-waiver Enrollee (or authorized representative) or by a provider (PCP or other provider rendering service) either orally or in writing.

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

Molina will do the following for External Independent Review:

- Molina will forward all medical records and supporting documentation, with a description of the applicable issues, and a statement of Molina’s decision along with the criteria used and medical and clinical reasons for the decision to the external independent reviewer. The External Independent Reviewer will evaluate and analyze the case and render a decision for all standard requests. The decision by the independent review is final. If the reviewer determines the health care service to be medically appropriate, Molina will pay for the service. Molina will notify the requestor orally and in writing of the results of the external independent review.
• The external independent reviewer will not be informed of the specific identity of the Member.
• The external independent reviewer must be a clinical peer and have no direct affiliation to Molina or financial interest in connection with the case in question.

(20.9) - Expedited External Independent Review

A request for an expedited independent review may be made orally or in writing. Molina will review the information and notify the requestor within twenty-four (24) hours of receipt of the request of information if it meets the criteria for an expedited timeframe that a standard timeframe could seriously risk the Enrollee’s life or health. Molina will ensure all external independent reviews are determined as expeditiously as possible, and no later than twenty-four (24) hours from receipt of the required information. If additional information is required to make the final appeal determination and it is not received within seventy-two (72) hours, a determination will be made with the current information available. Molina will notify the requestor orally of the results of the expedited external independent review within twenty-four (24) hours after receipt of the required information. Written notification will be sent within two (2) calendar days from the date the decision was made.

(20.10) - Continuation of benefits

Enrollees may file for a continuation of benefits on or before the latter of ten (10) days from the Adverse Benefit Determination, or the intended Effective Date of the proposed Adverse Benefit Determination. Molina will continue the Enrollee’s benefits during the Appeal process. A provider, serving as the Enrollee’s authorized representative for the Appeal process, cannot file for continuation of benefits.

(20.11) - Illinois Department of Healthcare and Family Services (HFS) Review

Enrollees not satisfied with the determination of the external independent reviewer may request a State Hearing. Parties to the review include Molina and the Enrollee (or authorized representative).

Requests for HFS review must be filed within one hundred twenty (120) days after the date of the Appeal Decision Letter. The request must be sent to HFS at the following address:

Illinois Department of Healthcare and Family Services
Bureau of Administrative Hearings
69 W. Washington, 4th Fl.
Chicago, IL 60602
Fax: (312) 793-2005
Or you may call (855) 418-4421
For hearing impaired, TTY at (800) 526-5812

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

(20.12) - Second opinion

If an Enrollee wishes to obtain a second opinion on the care they receive or plan to receive for covered health care services they may do so from an in-network provider at no cost. A Member can call Member Services to find out how to get a second opinion at no cost to the Member. Health Choice of Illinois (855) 687-7861. Members can call (855) 766-5462; TTY: 711, Monday-Friday, 8:00 a.m. - 5:00 p.m.

(20.13) - Member Grievance Process

Molina has an organized grievance process to ensure thorough, appropriate and timely resolution to Enrollees’ grievances. A grievance is an expression of dissatisfaction which may include but are not limited to;
- Requests for disenrollment
- Difficulty finding a provider
- Unhappy with the prior authorization process
- Services provided by Molina staff or Molina providers
- Reporting and analysis of grievances and appeals is performed regularly to identify trends and potential barriers in accessing care.

If a Member is unhappy with Molina or its providers they may file a grievance by contacting Member Services.

They can also write to us at:

Molina Healthcare of Illinois, Inc.
Attn: Appeals and Grievance
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523
Or
Via fax: (855) 502-5128

Enrollees are notified of their grievance through various general communications including, but not limited to, the Member Handbook, Evidence of Coverage and Disclosure, Member newsletters and Molina’s website.

Enrollees may identify an individual, including an attorney or provider, to serve as a personal representative to act on their behalf at any stage during the grievance. If under applicable law, a person has authority to act on behalf of an Enrollee in making decisions related to health care or is a legal representative of the Enrollee, Molina will treat such person as a personal representative. Providers are permitted to submit a grievance on behalf of Enrollee. However, signed consent from the Enrollee is required. Molina will ensure that no punitive action is taken against a provider who acts as an authorized representative on behalf of the Enrollee or supports a grievance filed by an Enrollee.

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

Any grievance or appeal with Potential Quality of Clinical Care (PQOC) is referred to the Quality Improvement (QI) Department for documentation and further investigation when appropriate. Additionally, any identified issue related to the Privacy and Confidentiality of Protected Health Information (PHI) is referred to the Privacy Officer.

(20.14) - Grievance Timelines

A Member may file a grievance of the incident or following the date the Member was made aware of the incident. A written acknowledgement of the grievance is sent to the Member within forty-eight (48) hours from receipt. A determination will be made as expeditiously as possible but no later than ninety (90) days from receipt of the Grievance. Molina will provide the Member (or designated representative) notification of outcome.

(20.15) - 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.

**(20.16) - Record Retention**

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

**(20.17) - MLTSS Program Appeals, Grievances, and State Hearings**

Molina maintains an organized and thorough grievance and appeal process to ensure timely, fair, unbiased and appropriate resolutions. Molina MLTSS Members, or their authorized representatives, have the right to voice a grievance or submit an appeal through a formal process.

Molina ensures that Members have access to the appeal process, by providing assistance throughout the whole procedure in a culturally and linguistically appropriate manner; including oral, written, and language assistance if needed. Grievance information is also included in the Member Handbook.

**Section 21 - Delegation**

This section contains information specific to medical groups, Independent Practice Associations (IPA), and Vendors contracted with Molina to provide medical care or services to Members, and outlines Molina’s delegation criteria and capitation reimbursement models. Molina will delegate certain administrative responsibilities to the contracted medical groups, IPAs, or vendors, upon meeting all of Molina’s delegation criteria. Provider capitation reimbursement models range from fee-for-service to full risk capitation.

**(21.1) - Delegation of Administrative Functions**

Administrative services which may be delegated to IPAs, Medical Groups, Vendors, or other organizations include:

- Call Center
- Care Management
- Claims Administration
- Credentialing
- Non-Emergent Medical Transportation (NEMT)
- Utilization Management (UM)

Credentialing functions may be delegated to Capitated or Non-Capitated entities, which meet National Committee for Quality Assurance© (NCQA©) criteria for credentialing functions. Call Center, Claims Administration, Care Management and/or Utilization Management functions are generally only delegated to Capitated entities.

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Vendors or full risk entities. Non-Emergent Medical Transportation (NEMT) may be delegated to Vendors who can meet Call Center, Claims Administration and/or NEMT requirements.

Note: The Molina Member’s ID card will identify which group the Member is assigned. If Claims Administration 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.

(21.2) - Delegation Criteria

Molina is accountable for all aspects of the Member’s health care delivery, even when it delegates specific responsibilities to sub-contracted IPAs, Medical Groups, or Vendors. Molina’s Delegation Oversight Committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements.

(21.3) - Call Center

To be delegated for Call Center functions, Vendors must:

- Have a Vendor contract with Molina (Molina does not delegate call center functions to IPAs or Provider Groups).
- Have a Call Center delegation pre-assessment completed by Molina to determine compliance with all applicable State and Federal regulatory requirements.
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30) days.
- Correct deficiencies within the timeframes identified in the corrective action plan (CAP) when issues of non-compliance are identified by Molina.
- Protect the confidentiality of all PHI as required by Law.
- Have processes in place to identify and investigate potential Fraud, Waste and Abuse.
- Must have an automated call system that allows the Vendor to confirm Member benefits and eligibility during the call.
- Agree to Molina’s contract terms and conditions for Call Center delegates.
- Submit timely and complete Call Center delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contract.
- Current call center is able to demonstrate compliance with service level performance, average speed to answer, abandonment rate, and/or percentage of calls that are complaints meet CMS and/or state requirements, depending on the line(s) of business delegated.

A Vendor may request Call Center delegation from Molina through Molina’s Delegation Oversight Manager or through the Vendor’s Contract Manager. Molina 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 Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate Call Center responsibilities is based on the Vendor’s ability to meet Molina, State and Federal requirements for delegation.

(21.4) - Care Management

To be delegated for Care Management functions, Medical Groups, IPAs and/or Vendors must:

- Be certified by the National Committee for Quality Assurance (NCQA) © for complex case management and disease management programs.
- Have a current complex case management and disease management program descriptions in place.
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30) days.
• Pass a care management pre-assessment audit, based on NCQA® and State requirements, and Molina business needs.
• Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina.
• Agree to Molina’s contract terms and conditions for care management delegates.
• Submit timely and complete Care Management delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
• Comply with all applicable federal and state Laws.

Note: Molina does not allow care management delegates to further sub-delegate care management activities.

A Medical Group, IPA, or Vendor may request Care Management delegation from Molina through Molina’s Delegation Oversight Manager or through the Medical Group, IPA, or Vendor’s Contract Manager. Molina 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 Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate Care Management responsibilities is based on the Medical Group, IPA, or Vendor’s ability to meet Molina, State and Federal requirements for delegation.

(21.5) - Claims Administration

To be delegated for Claims Administration, Medical Groups, IPAs, and/or Vendors must do the following:

• Have a capitation contract with Molina and be in compliance with the financial reserves requirements of the contract.
• Be delegated for UM by Molina.
• Protect the confidentiality of all PHI as required by Law.
• Have processes in place to identify and investigate potential Fraud, Waste, and Abuse.
• Have a Claims Administration delegation pre-assessment completed by Molina to determine compliance with all applicable State and Federal regulatory requirements for Claims Administration.
• Correct deficiencies within timeframes identified in the corrective action plan (CAP) when issues of non-compliance are identified by Molina.
• Must have an automated system capable of accepting electronic claims in an ICD 10 compliant format.
• Must have an automated system capable of providing Molina with the Encounter Data required by the state in a format readable by Molina.
• Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30) days.
• Agree to Molina’s contract terms and conditions for Claims Delegates.
• Submit timely and complete Claims Administration delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
• Within 30 days of the end of the month in which care was rendered, provide Molina 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 (30) days of Molina’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’s contract terms to pay for services rendered by Providers not contracted with IPA or group, follow Molina’s Claims Administration policies and guidelines, such as the retroactive authorization policy and guidelines for Claims adjustments and review of denied Claims.
A Medical Group, IPA, or Vendor may request Claims Administration delegation from Molina through Molina’s Delegation Oversight Manager or through the Medical Group, IPA, or Vendor’s Contract Manager. Molina 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 Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate Claims Administration responsibilities is based on the Medical Group, IPA, or Vendor’s ability to meet Molina, State and Federal requirements for delegation.

(21.6) - Non-Emergent Medical Transportation (NEMT)

To be delegated for NEMT functions, Vendors must do the following:

- Have a Vendor contract with Molina (Molina does not delegate NEMT functions to IPAs or Medical Groups).
- Pass Molina’s NEMT pre-assessment, which is based on State and Federal NEMT requirements.
- Have automated systems that allow for scheduling of NEMT appointments, confirmation of Member eligibility, and availability of NEMT benefits.
- Have processes in place to ensure protection of Member PHI.
- Have processes in place to identify and investigate potential Fraud, Waste, and Abuse.
- Have a network of vehicles and drivers that meet State and Federal safety requirements.
- Ensure on at least an annual basis that vehicles continue to meet State and Federal vehicle safety requirements.
- Ensure that drivers continually meet State and Federal safety requirements.
- Have a process in place for reporting of all accidents, regardless of harm to Member, to Molina within forty-eight (48) hours.
- Agree to Molina’s contract terms and conditions for NEMT delegates, including applicable Call Center and/or Claims Administration delegation requirements.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina.
- Submit timely and complete NEMT delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Comply with all applicable Federal and State Laws.

Note: If the NEMT Vendor delegates to other sub-contractors, the NEMT Vendor must have a process to ensure that their sub-contractors meet all Health Plan and State and Federal requirements identified above. Evaluation should be done prior to execution of a contract, and annually thereafter. Evaluation should include review of compliance with driver requirements, vehicle requirements, Health Plan, State and Federal requirements, and a process to implement corrective action if issues of non-compliance are identified.

A vendor may request NEMT delegation from Molina through Molina’s delegation manager or through the vendor’s contract manager. Molina 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 NEMT is based on the vendor’s ability to meet Molina’s standards and criteria for delegation.

(21.7) - Utilization Management (UM)

To be delegated for UM functions, Medical Groups, IPAs, and/or Vendors must:

- Have a UM program that has been operational at least one year prior to delegation, and includes an annual UM Program evaluation and annual Inter Rater Reliability audits of all levels of UM staff.
- Pass Molina’s UM pre-assessment, which is based on NCQA®, State and Federal UM standards, and Molina Policies and Procedures.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina.
- Ensure that only licensed physicians/dentists medical necessity denial decisions.
- Ensure that only appropriate levels of clinical staff make medical necessity approval decisions.
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30) days.
- Agree to Molina’s contract terms and conditions for UM delegates.
- Submit timely and complete UM delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- 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.

Note: If the Medical Group, IPA, or Vendor is an NCQA© Certified or Accredited organization, a modified pre-assessment audit may be conducted. Modifications to the audit depend on the type of Certification or Accreditation the Medical Group, IPA, or Vendor has, but will always include evaluation of applicable State requirements and Molina Business needs.

Molina does not allow UM delegates to further sub-delegate UM activities.

A Medical Group, IPA, or Vendor may request UM delegation from Molina through Molina’s Delegation Oversight Manager or through the Medical Group, IPA, or Vendor’s Contract Manager. Molina 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 Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate UM responsibilities is based on the Medical Group, IPA, or Vendor’s ability to meet Molina, State and Federal requirements for delegation.

(21.8) - Quality Improvement/Preventive Health Activities

Molina does not delegate Quality Improvement activities to Provider organizations. Molina will include all network providers, including those in Medical Groups, IPAs, or Vendors who are delegated for other functions (Claims, Credentialing, UM, etc.) in its Quality Improvement Program activities and preventive health activities. Molina encourages all contracted Provider organizations to conduct activities to improve the quality of care and service provided by their organization. Molina would appreciate receiving copies of studies conducted or data analyzed as part of the Medical Group, IPA, or Vendor’s Quality Improvement Program.

(21.9) - Delegation Reporting Requirements

Medical Groups, IPAs, or Vendors contracted with Molina and delegated for various administrative functions must submit monthly and quarterly reports determined by the function(s) delegated to the identified Molina Delegation Oversight Staff within the timeline indicated by the Health Plan. For a copy of Molina’s current delegation reporting requirements, please contact your Molina Provider Services Contract Manager.

Section 22 - Cultural Competency and Linguistic Services

(22.1) - Background
Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the US Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina complies with Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA) Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) and other regulatory/contract requirements. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency and Members who are deaf, hard of hearing or have speech or cognitive/intellectual impairments. Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds, gender, gender identity, sexual orientation, age and religions as well as those with disabilities in a manner that recognizes values, affirms and respects the worth of the individuals and protects and preserves the dignity of each.

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

(22.2) - Nondiscrimination of Healthcare Service Delivery

Molina complies with the guidance set forth in the final rule for Section 1557 of the ACA, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina website home pages. All Providers who join the Molina Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Molina requires Providers to deliver services to Molina Members without regard to race, color, national origin, age, disability or sex. This includes gender identity, sexual orientation, pregnancy and sex stereotyping. Providers must post a non-discrimination notification in a conspicuous location of their office along with translated non-English taglines in the top fifteen (15) languages spoken in the state to ensure Molina Members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred.

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

Members can also email the complaint to civil.rights@molinahealthcare.com. Should you or a Molina Member need more information you can refer to the Health and Human Services website for more information: https://www.federalregister.gov/d/2016-11458

(22.3) - Section 1557 Investigations

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

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

Toll Free: (866) 606-3889
TTY/TDD: 711
(22.4) - Molina Institute for Cultural Competency

Molina is committed to reducing healthcare disparities. Training employees, Providers and their staffs, and quality monitoring are the cornerstones of successful culturally competent service delivery. Molina founded the Molina Institute for Cultural Competency, which integrates Cultural Competency training into the overall Provider training and quality monitoring programs. An integrated quality approach intends to enhance the way people think about our Members, service delivery and program development so that cultural competency becomes a part of everyday thinking.

(22.5) - Provider and Community Training

Molina offers educational opportunities in cultural competency concepts for Providers, their staff, and Community Based Organizations. Molina conducts Provider training during Provider orientation with annual reinforcement training offered through Provider Network Management or online training modules.

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

- Written materials;
- On-site cultural competency training delivered by Provider Network Manager;
- Access to enduring reference materials available through Health Plan representatives and the Molina website; and
- Integration of cultural competency concepts and nondiscrimination of service delivery into Provider communications

(22.6) - Integrated Quality Improvement – Ensuring Access

Molina ensures Member access to language services such as oral interpreting, American Sign Language (ASL), written translation and access to programs, and aids and services that are congruent with cultural norms. Molina supports Members with disabilities, and assists Members with Limited English Proficiency.

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

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

(22.7) - Program and Policy Review Guidelines

Molina conducts assessments at regular intervals of the following information to ensure its programs are most effectively meeting the needs of its Members and Providers:

- Annual collection and analysis of race, ethnicity and language data from:
  - Eligible individuals to identify significant culturally and linguistically diverse populations with plan’s Membership
  - Revalidate data at least annually
  - Contracted Providers to assess gaps in network demographics
• Local geographic population demographics and trends derived from publicly available sources (Group Needs Assessment)
• Applicable national demographics and trends derived from publicly available sources
• Network Assessment
• Collection of data and reporting for the Diversity of Membership HEDIS measure.
• Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages.
• Identification of specific cultural and linguistic disparities found within the plan’s diverse populations.
• Analysis of HEDIS and CAHPS results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.
• 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) Linguistic Services
• Measures available through national testing programs such as the National Health and Nutrition Examination Survey (NHANES) Linguistic Services

Molina 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 notifies plan Members of the availability of oral interpreting services upon enrollment, and informs them how to access oral interpreting services at no cost to them on all significant Member materials. Molina serves a diverse population of Members with specific cultural needs and preferences. Providers are responsible for supporting access to interpreter services at no cost for Members with sensory impairment and/or who have Limited English Proficiency.

(22.8) - 24 Hour Access to Interpreter Services

Providers may request interpreters for Members whose primary language is other than English by calling Molina’s Member Services toll free at (855) 687-7861. If Member Services Representatives are unable to interpret in the requested language, the Representative will immediately connect you and the Member to a language service provider. Molina Providers must support Member access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset. Providers may offer Molina Members interpreter services if the Members do not request them on their own. It is never permissible to ask a family member, friend or minor to interpret.

(22.9) - Documentation

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

Record the Member’s language preference in a prominent location in the medical record. This information is provided to you on the electronic Member lists that are sent to you each month by Molina.

Document all Member requests for interpreter services.

Document who provided the interpreter service. This includes the name of Molina’s internal staff or someone from a commercial interpreter service vendor. Information should include the interpreter’s name, operator code and vendor.
Document all counseling and treatment done using interpreter services.

Document if a Member insists on using a family member, friend or minor as an interpreter, or refuses the use of interpreter services after notification of his or her right to have a qualified interpreter at no cost.

(22.10) - Members with Hearing Impairment

Molina provides a TTY/TDD connection accessible by dialing 711. This connection provides access to Member & Provider Contact Center (M&PCC), Quality, Healthcare Services and all other health plan functions.

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

Molina will provide face-to-face service delivery for ASL to support our Members with hearing impairment. Requests should be made three days in advance of an appointment to ensure availability of the service. In most cases, Members will have made this request via Molina Member Services.

(22.11) Nurse Advice Line

Molina provides twenty four (24) hours/seven (7) days a week Nurse Advice Services for Members. The Nurse Advice Line provides access to twenty-four (24) hour interpretive services. Members may call Molina’s Nurse Advice Line directly (English line (888) 275-8750) or (Spanish line at (866) 648-3537) or for assistance in other languages. The Nurse Advice TTY/TDD is 711. The Nurse Advice Line telephone numbers are also printed on Membership cards.

(22.12) - Provider and Community Training

Molina 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 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 website
- Integration of cultural competency concepts into provider communications
- CME

(22.13) - Integrated Quality Improvement
Molina 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 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 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 Member website.

(22.14) - Program and Policy Review Guidelines

Molina 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 23 - HIPAA Requirements and Information

The Health Insurance Portability and Accountability Act (HIPAA)

(23.1) - Molina Healthcare’s Commitment to Patient Privacy

Protecting the privacy of Members’ personal health information is a core responsibility that Molina takes very seriously. Molina is committed to complying with all federal and state laws regarding the privacy and security of Members’ PHI.

(23.2) - Provider/Practitioner Responsibilities

Molina expects that its contracted providers/practitioners will respect the privacy of Molina Members and comply with all applicable laws and regulations regarding the privacy of patient and Member PHI.

(23.3) - 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:
(23.4) - Federal Laws and Regulations

- HIPAA
- The Health Information Technology for Economic and Clinical Health Act (HITECH)
- Medicare and Medicaid Laws
- The Affordable Care Act

State Medical Privacy Laws and Regulations.

Providers should be aware that HIPAA provides a floor for patient privacy but that State Laws should be followed in certain situations, especially if the State Law is more stringent than HIPAA. Providers should consult with their own legal counsel to address their specific situation.

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.

(23.5) - 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. 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. 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 for our healthcare operations activities, such as HEDIS and QI.

(23.6) - Inadvertent Disclosures of PHI

Molina may, on occasion, inadvertently misdirect or disclose PHI pertaining to Molina Member(s) who are not the patients of the Provider. In such cases, the Provider shall return or securely destroy the PHI of the affected Molina Members in order to protect their privacy. The Provider agrees to not further use or disclose such PHI, unless otherwise permitted by Law.

(23.7) - 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 Form is included at the end of this section.

(23.8) - Patient Rights

Patients are afforded various rights under HIPAA. Molina providers/practitioners must allow patients to exercise any of the below-listed rights that apply to the provider/practitioner’s practice:

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

(23.9) - 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.

(23.10) - 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.

(23.11) - 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.

(23.12) - 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.

(23.13) - Request to Amend PHI

Patients have a right to request that the provider/practitioner amend information in their designated record set.

(23.14) - 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.

(23.15) - 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.

(23.16) - HIPAA Transactions and Code Sets

Molina strongly supports the use of electronic transactions to streamline healthcare administrative activities. Molina providers/practitioners are encouraged to submit claims and other transactions to Molina 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 is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers/practitioners who wish to conduct HIPAA standard transactions with Molina 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.”

(23.17) - Code Sets

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

(23.18) - 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 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 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.

(23.19) - Additional Requirements for Delegated Providers/Practitioners

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