Medicaid Provider Manual

- Integrated Care Program (ICP)
- Family Health Plan (FHP)

Molina Healthcare of Illinois
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Oak Brook, IL 60523
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Phone: (888) 858-2156
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Dear Provider:

I would like to extend a personal welcome to Molina Healthcare of Illinois. The following is your Molina Healthcare Provider Manual, written specifically to address the requirements of delivering health care services to Molina Healthcare Medicaid Members.

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

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

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

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

Sincerely,

Cathy Harvey
Plan President
Molina Healthcare of Illinois
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MOLINA HEALTHCARE OF ILLINOIS CONTACT INFORMATION

Member Services Department
Molina Healthcare of Illinois’ (Molina Healthcare) Member Services Department handles all telephone and written inquiries regarding Member claims, benefits, eligibility/identification, selecting or changing Primary Care Providers (PCPs), and Member complaints. Member Services Representatives are available 8 a.m. to 5 p.m., CST/CDT Monday through Friday, excluding State holidays.

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<thead>
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<th>Member Services</th>
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<tbody>
<tr>
<td>Address: Molina Healthcare of Illinois</td>
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<tr>
<td>1520 Kensington Rd., Suite 212</td>
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<tr>
<td>Oak Brook, IL 60523</td>
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<tr>
<td>Phone: (855) 766-5462 (Integrated Care)</td>
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<tr>
<td>Phone: (855) 687-7861 (Family Health Plan)</td>
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<td>TTY: 711</td>
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Claims Department
The Claims Department is located at our corporate office in Long Beach, CA. All hard copy (CMS-1500, UB-04) claims must be submitted by mail to the address listed below. Electronically filed claims must use Payor ID number 20934. To verify the status of your claims, please call Provider Services at the number listed below.

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<tr>
<td>Address: Molina Healthcare of Illinois</td>
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<tr>
<td>PO Box 540</td>
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<tr>
<td>Long Beach, CA 90801</td>
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<td>Phone: (855) 866-5462</td>
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Credentialing Department
The Credentialing Department verifies all information on the Practitioner Application prior to contracting and re-verifies this information every three years. The information is then presented to the Professional Review Committee to evaluate a provider’s qualifications to participate in the Molina Healthcare network.

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<th>Credentialing</th>
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<td>Address: Molina Healthcare of Illinois</td>
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<tr>
<td>Credentialing Department</td>
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<tr>
<td>1520 Kensington Road Suite 212</td>
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<tr>
<td>Oak Brook, IL 60523</td>
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<td>Phone: (855) 866-5462</td>
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<td>Fax: (630) 571-1220</td>
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24-Hour Nurse Advice Line
This telephone-based nurse advice line is available to all Molina Healthcare Members. Members may call anytime they are experiencing medical or behavioral health symptoms or need health care information. Registered nurses are available 24 hours a day, seven days a week to assess symptoms and help make good health care decisions.
Utilization Management
The Utilization Management (UM) Department conducts concurrent review on inpatient cases and processes Prior Authorization requests.

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<th>Utilization Management</th>
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<td>Address: Molina Healthcare of Illinois</td>
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<td>1520 Kensington Rd., Suite 212</td>
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<td>Oak Brook, IL 60523</td>
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<tr>
<td>Phone: (855) 866-5462</td>
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<td>Fax: (866) 617-4971</td>
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Case Management
Case Management is provided 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.

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<tr>
<td>1520 Kensington Rd., Suite 212</td>
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<td>Phone: (888) 858-2156</td>
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<td>Fax: (800) 642-5270</td>
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Quality Improvement
The Quality Improvement Department works with Members and practitioners/providers in administering the Molina Healthcare Quality Improvement Program (QIP).

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<td>1520 Kensington Rd., Suite 212</td>
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<tr>
<td>Oak Brook, IL 60523</td>
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<tr>
<td>Phone: (855) 866-5462</td>
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<tr>
<td>Fax: (855) 556-2074</td>
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Behavioral Health
Molina Healthcare covers all behavioral health Medicaid services and manages all components of behavioral health for Molina Healthcare Members.
**Behavioral Health**

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

**Provider Services**

Molina Healthcare’s Provider Services Department handles telephone and written inquiries from providers regarding address and Tax-ID changes, provider denied claims review, contracting, and training. The department has Provider Services Representatives serving the entire Molina Healthcare service area.

| Address: Molina Healthcare of Illinois  
| 1520 Kensington Rd., Suite 212  
| Oak Brook, IL 60523  
| Phone: (855) 866-5462 |

**Pharmacy Department**

Pharmacy services are covered according to the Molina Healthcare Drug Formulary. The formulary and a list of in-network pharmacies are available online at [www.molinahealthcare.com](http://www.molinahealthcare.com). Prior Authorization requests for drugs not listed on the Molina Healthcare Drug Formulary can be faxed to (855) 365-8112 or called into the MHIL Pharmacy Department at (855) 866-5462.

**Dental**

Avesis is the dental vendor for MHIL. To locate dental providers for Integrated Care Program and Family Health Plan Members, call Avesis at (866) 857-8124.

**Vision**

March Vision Care is the vision vendor for MHIL. To locate vision providers, call March Vision Care at (844) 456-2724.

**Non-Emergency Transportation**

Secure Transportation is the non-emergency transportation vendor for MHIL. ICP Members may call Secure Transportation at (844) 644-6354 to schedule a ride. Family Health Plan Members should call (844) 644-6354 to schedule a ride.
Section 2
MOLINA MEDICAID PROGRAMS

Section 2.1 Integrated Care Program (ICP)

The Integrated Care Program (ICP) is a medical program for older adults and disabled adults, who are enrolled in Medicaid through the Illinois Department of Healthcare and Family Services (HFS), but do not qualify for Medicare.

It is a mandatory program for HFS clients in the ICP population, which HFS terms Seniors and Person with Disabilities (SPD). Also included in the ICP population are patients who qualify for Long Term Care and those who are eligible for the following 1915c Medicaid waivers: elderly, disabled, HIV/AIDS, traumatic brain injury, and supportive living facility.

In ICP, Members must select a health plan and a doctor or clinic to serve as their Primary Care Provider (PCP) for their medical home. ICP brings together local PCPs, specialists, hospitals, nursing homes and other providers to organize care around a patient’s needs. This program promotes health and wellness.

Molina Healthcare is an ICP health plan option for HFS clients who live in two regions: Central Illinois and Metro East.

- The Central Illinois region consists of these counties: Champaign, Christian, DeWitt, Ford, Knox, Logan, Macon, McLean, Menard, Peoria, Piatt, Sangamon, Stark, Tazewell, and Vermilion.

- Metro East consists of these counties: Clinton, Madison, and St. Clair.

HFS clients are excluded from ICP participation if: they are less than 19 years old; have Medicare; are enrolled in Spenddown program; get temporary medical benefits; are in the Illinois Breast and Cervical Cancer program; or, already have insurance that covers hospital and doctor visits. American Indians and Native Alaskans may choose to voluntarily enroll in an ICP health plan.

Section 2.2 Family Health Plan (FHP)

The Family Health Plan (FHP) is a comprehensive, patient-centered medical program for children and adults whose primary insurance is the HFS medical card. Members will select a managed care (MCO) health plan and a Primary Care Provider to serve as their medical home.

It is a mandatory program for the FHP population living in certain geographic regions. Molina Healthcare was selected to be a FHP health plan in Central Illinois, Cook and Metro East. Molina Healthcare expanded into Cook County beginning January 1, 2016.

- The Central Illinois region consists of these counties: Champaign, Christian, DeWitt, Ford, Knox, Logan, Macon, McLean, Menard, Peoria, Piatt, Sangamon, Stark, Tazewell, Vermilion.

- Cook County

- Metro East consists of these counties: Clinton, Madison, St. Clair.
Most people with an HFS medical card in Central Illinois and Metro East must select a Family Health plan. This is a Medicaid-only program for HFS 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.

Not all HFS medical card holders in Central Illinois and Metro East are required to select a Family Health Plan MCO health plan. Excluded populations for FHP:

- Comprehensive Third Party Liability insurance
- 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 less than 19 years old who get Supplemental Security Income
- Children less 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.)

Family Case Management (2.2.1)
The Illinois Department of Human Services (DHS) contracts with Local Health Departments and Federally Qualified Health Centers to provide Family Case Management 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 Healthcare 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.

Women, Infants and Children (WIC) Program (2.2.2)
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

WIC coordinates services with other community maternal, prenatal and child health care services for the targeted high-risk population. It is a prevention program designed to influence
lifetime nutrition and health behaviors. Providers are encouraged to refer patients included in the targeted population for WIC evaluation.

**Early Intervention (2.2.3)**
Early Intervention is a DHS program for children less than 36 months of age, who have disabilities, delays or who are at a substantial risk of 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 the DHS Child and Family Connections (CFC) office, which serves their local area. These regional offices provide:

- Service coordination
- Assist 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 working days after a child has been identified with a disability or possible developmental delay.

**School-Based/Linked Health Centers (2.2.4)**
DHS funds school-based/linked health centers that 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 referral.

School-Based/Linked Health Center services are direct access for FHP Members less 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
Section 2.3 Molina Healthcare of Illinois Service Map

- **Cook County Region:** Medicaid - FHP Only
  1/1/2016 Effective

- **Central Region:** Medicaid - ICP & FHP
  Medicare and Medicaid - MMP

- **Metro East Region:** Medicaid - ICP & FHP
Section 2.4 Enrollment in Medicaid Programs

The Illinois Medical Assistance Program is the program which implements Title XIX of the Social Security Act (Medicaid). HFS administers Medicaid under the Illinois Public Aid Code. Through an interagency 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, the Member, Member representative, or their responsible parent or guardian must complete and submit an application to DHS. This can be done by visiting the nearest DHS office, or where health reasons prohibit visiting an office, by contacting DHS to have an application mailed. Mailed applications will be followed-up by a telephone interview. It is also possible to enroll for HFS medical benefits through the DHS website.

The Illinois Department of Human Services can be contacted at:

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

Illinois Client Enrollment Services and HFS Health Plan Assignment (2.4.1)

Only HFS clients who are included in the eligible populations and living in counties with authorized health plans are eligible to enroll and receive services from Molina Healthcare.

Clients must contact **Illinois Client Enrollment Services (ICES)** to select Molina Healthcare as their health plan. Molina Healthcare participates in the following HFS programs: the Integrated Care Program (ICP) for elderly or disabled adults, the Medicare-Medicaid Alignment Initiative (MMAI) for dual eligible Members, Managed Long Term Services and Supports (MLTSS) for waiver beneficiaries who opt out of MMAI, and the Family Health Plan for children and adults.

Illinois Client Enrollment Services can be contacted at:

- **ICES website:** [http://www.enrollhfs.illinois.gov](http://www.enrollhfs.illinois.gov)
- **Toll Free at:** (877) 912-8880
- **TTY:** (866)565-8576

ICES will assist all eligible Members with selecting a health plan of their choice. If the Member does not choose a plan, ICES will passively assign the Member 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.

Effective Date of HFS Eligibility (2.4.2)

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.
Inpatient at Time of Enrollment (2.4.3)
Regardless of what program or health plan the Member is enrolled in at discharge, the program or plan the Member is enrolled with on the date of admission shall be responsible for payment of all covered inpatient facility and professional services provided from the date of admission until the date the Member is no longer confined to an acute care hospital.

Section 2.5 Member Eligibility Verification
HFS determines eligibility for the Medicaid programs. Payment for services rendered is based on eligibility and benefit entitlement. The contractual agreement between providers and Molina Healthcare places the responsibility for eligibility verification on the provider of services.

HFS Eligibility Verification Systems (2.5.1)
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](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.

Molina Healthcare Member Eligibility Verification (2.5.2)
Providers who contract with Molina Healthcare may verify a Member’s eligibility and/or confirm PCP assignment by checking the following:

Molina Healthcare Provider Services at (888) 858-2156
The Provider Self Services section of the Molina Healthcare Web Portal at:

[http://www.molinahealthcare.com](http://www.molinahealthcare.com)

Possession of a Medicaid ID Card does not mean a recipient is eligible for Medicaid services. A provider should verify a recipient’s eligibility each time the recipient receives services. The verification sources can be used to verify a recipient’s enrollment in a managed care plan. The name and telephone number of the managed care plan are given along with other eligibility information.
Section 2.6 Molina Healthcare Identification Cards

Molina Healthcare Sample Member ID cards:

Family Health Plan ID Card – Front
IL Medicaid Family Health Plan-Medicaid IL TANF ID Card

Integrated Care Program ID Card – Front
Medicaid IL Card

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

Section 2.7 Member Disenrollment

Voluntary Disenrollment (2.7.1)
Members have the right to request to change plans at any time. Members should call ICES at (877) 912-8880 for education and assistance in selecting another health plan and PCP. Disenrollment can take four to six weeks, and will be effective at 11:59 p.m. on the last day of the month following the month HFS processes the disenrollment.

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

Involuntary Disenrollment (2.7.)
Under very limited conditions and in accordance with HFS guidelines, Members may be involuntarily disenrolled from a managed care program. With proper written documentation and HFS approval,
the following are acceptable reasons for which Molina Healthcare may submit Involuntary
Disenrollment requests to HFS of ICES:

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

Section 2.8 Disenrollment / 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 Healthcare 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.

A Member may only be considered for an involuntary disenrollment after the Member has had
at least one verbal warning and at least one written warning of the full implications of their
failure of actions. The Member must receive written notification at a sixth grade reading level
from the PCP explaining in detail the reasons for dismissal from the practice. Action related to
request for involuntary disenrollment conditions must be clearly documented by providers in the
Member’s records and submitted to Molina Healthcare. The documentation must include
attempts to bring the Member into compliance. A Member’s failure to comply with a written
corrective action plan (CAP) must be documented. For any action to be taken, it is mandatory
that copies of all supporting documentation from the Member’s file are submitted with the
request. Molina Healthcare will contact the Member to educate the Member about the
consequences of the behavior that is disruptive, unruly, abusive or uncooperative and/or
Member until the Member is transitioned to a new PCP. HFS is the final approving authority
for all disenrollment requests.

In the event a Member appeals a disenrollment decision through the HFS appeals process,
HFS may require Molina Healthcare to continue to provide services to the Member under the
terms of the contract pending the final decision. Molina Healthcare would continue to provide
services either by the current PCP or by another medical practice. Should the Member’s
behavior be a danger or threat to safety or the property of Molina Healthcare, its staff,
providers, or other patients, Molina Healthcare will contact HFS to request an immediate
involuntary disenrollment.
Section 2.9 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 Healthcare will offer each Member a choice of PCPs. After making a choice, each Member will have a single PCP.

Molina Healthcare will allow pregnant Members to choose the health plan’s obstetricians as their PCPs to the extent that the obstetrician is willing to participate as a PCP. Providers shall advise all Members of the Members’ responsibility to notify Molina Healthcare and HFS of their pregnancies and the births of their babies.

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

Section 2.10 PCP Changes

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

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

The following explains the rights and responsibilities of Molina Healthcare 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.

Section 3.1 Member Rights

Members of Molina Healthcare have the following 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 Healthcare, its services, its practitioners and providers
- Members’ right and responsibilities to make recommendations about Molina Healthcare’s ‘Member rights and responsibilities policies
- To voice complaints or appeals about the organization or the care it provides
- To express grievance regarding any violation of your rights, as stated in Illinois law, through the grievance procedure of the health care provider or health care facility which you and to
the appropriate state licensing agency listed below:

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

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

Section 3.2 Member Responsibilities

Members of Molina Healthcare have the responsibility:

- 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

Section 3.3 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 4
BENEFITS AND COVERED SERVICES

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

Section 4.1 Co-Payments

There are no Member co-payments associated with covered services provided through Molina Healthcare’s coverage programs. Some benefits may have limitations.

Please call Provider Services for additional information or for a complete list of benefits at (888) 858-2156.

Section 4.2 Covered Services

Covered Services include:

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

Section 4.3 Services Not Covered

Elective cosmetic surgery
Custodial care services
Elective abortions
Infertility services

Section 4.4 Prescription Drugs
Prescription drugs are covered through Molina Healthcare. A list of in-network pharmacies is available:

Online at: www.molinahealthcare.com
Via phone at: (888) 858-2156.

Section 4.5 Injectable and Infusion Services

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

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

Section 4.6 Behavioral Health Services

PCPs can refer Members in need of behavioral health services or Members can self-refer by calling:

Molina Healthcare Behavioral Health Department at: (888) 858-2156

Molina Healthcare 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

Emergency Behavioral Health Services (4.6.1)
Members are directed to call 911 or go to the nearest emergency room if they need emergency behavioral health services. Examples of emergency behavioral health problems are:

- Danger to self or others
- Not being able to carry out daily activities
- Things that will likely cause death or serious bodily harm

Out of Area Emergency Services (4.6.2)
Members having a behavioral health emergency who cannot get to a Molina Healthcare approved providers are directed to do the following:

- Go to the nearest hospital or facility
- Call the number on ID card
• Call Member’s PCP and follow up within 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.

**Screening, Assessment and Support Services (SASS) Program (4.6.3)**

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, support to children and families when a child is hospitalized, post-discharge continuity of care, case management, transitional programming and psychiatric treatments 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
• Geographically dispersed screening agents knows as SASS providers

**SASS-like Services for Family Health Plan Members (4.6.3.1)**

HFS requires Molina Healthcare to provide Mobile Crisis Response Services (SASS-like services) as part of the covered benefits available to Members less than 21 years old.

Molina Healthcare has contracted with and will utilize the existing SASS providers and referrals from the CARES line to deliver Mobile Crisis Response Services (SASS-like services). All contracted SASS providers will be expected to meet the requirements for Mobile Crisis Response Services.

CARES can be reached at: (800) 345-9049

**Mobile Crisis Response Services (4.6.3.2)**

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 Healthcare FHP Members who are less than 21 years old and are experiencing a behavioral health crisis.

• SASS provider must respond to CARES call within 30 minutes.
• 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 case disposition to the Molina Healthcare Case Management department within 24 hours.

Provider Credentials (4.6.3.3)
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
• Licensed Practitioner of the Healing Arts

State Approved Screening Tool (4.6.3.4)
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 the Molina Healthcare.
• Providers must utilize the CSPI for each screening of the Member throughout the duration of the case.

Community Stabilization (4.6.3.5)
Mobile Crisis Response Services providers, in the event a Member in crisis can be stabilized in the community, must provide 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 and 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.
Crisis Safety Plan Development (4.6.3.6)
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 and actionable 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 with 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 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 Member from the facility.

Inpatient Institutional Treatment (4.6.3.7)
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 Member’s parent(s)/guardian(s)/caregiver(s) 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’s admission evaluation.

Once a Member has been admitted to an inpatient facility following a SASS screening, Molina Healthcare 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 Member’s family and Molina Healthcare 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 the 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 and the discharge meeting.
• Following up and coordinating with the parent, guardian or caregiver to facilitate the child’s return to his/her home.

**Care Coordination (4.6.3.8)**

Providers responsible for administering Mobile Crisis Response Services must 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 Healthcare 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, child 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 provider(s) as necessary and maintain communication with that provider throughout the duration of the child’s involvement with Mobile Crisis Response Services.

The communications should begin early in the process to assist with assessment and continue regarding treatment planning, progress in care and discharge planning.

**Reporting (4.6.3.9)**

Within five working days of initiating a face-to-face crisis screening, providers responsible for administering Mobile Crisis Response Services must provide a report on the following metrics:

- Time to respond to the CARES call
- Time to initiate a screening post-referral
- Time to complete screening post-referral
- All clinical CSPI data
- Screening outcome
- Initiated
- Completed
  - Served in community
  - Hospitalized
- Incomplete service
- Declined service
- Outcome not recorded

The report on the above metrics should be submitted to:

Email: MHILBehavioralHealthReferrals@molinahealthcare.com
Fax: (866) 916-3249

**Section 4.7 Long Term Services and Supports (LTSS)**

Certain Molina Healthcare Members are eligible for Long Term Services and Supports (LTSS) depending on their 1915c Medicaid Waiver eligibility. The following waivers are
included in the Integrated Care Program population: elderly, disability, HIV/AIDS, traumatic brain injury and supportive living facility.

The following services are coordinated through Molina Healthcare’s Medical Management Program:

<table>
<thead>
<tr>
<th>Services</th>
<th>Elderly</th>
<th>Disability</th>
<th>HIV/AIDS</th>
<th>Brain Injury</th>
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<td>Adult Day Service Transportation</td>
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<tr>
<td>Supported Employment</td>
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<tr>
<td>Behavioral Services</td>
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Section 4.8 Preventive Services

Adult Well Visits (4.8.1)
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 Healthcare.

Molina Healthcare 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.

Adult Risk Assessments (4.8.2)
Providers should screen and can bill for the following risk assessment screenings for adult women: preconception risk assessment and perinatal depression screening using CPT code
99420. 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.

**Adult Immunizations (4.8.3)**
Adult Members may receive immunizations as recommended by the Centers for Disease Control and Prevention (CDC) and prescribed by the Member’s PCP. Molina Healthcare covers all medically necessary immunizations for adults, including annual flu shots. For the current CDC adult immunization schedule, visit: [http://www.cdc.gov/vaccines/schedules/index.html](http://www.cdc.gov/vaccines/schedules/index.html).

**Pregnancy Care (4.8.4)**

**Normal Pregnancy**
Molina Healthcare Members should receive comprehensive parental evaluation and care based on the latest recommendations from the American College of Obstetrics and Gynecology and American Academy of Family Physicians, as evidenced in the prenatal schedule listed below. Provision of care should include: nutritional assessment and counseling, perinatal depression screening, health history, comprehensive exams, lab tests, risk assessments, anticipatory guidance and appropriate referrals.

*Stage of Pregnancy How often to see the doctor*
- 1 month – 6 months One visit a month
- 7 months – 8 months Two visits a month
- 9 months One visit a week

Women are eligible for all CDC recommended immunizations and a postpartum visit after delivery for a normal pregnancy. Molina Healthcare publishes annual preventive health guidelines for pregnant women. The guidelines are posted online at [www.molinahealthcare.com](http://www.molinahealthcare.com). 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.

**High-Risk Pregnancy**
Although pregnancy itself is not considered a disease state, a significant percentage of pregnant women 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. For more information about Motherhood Matters and other health management programs, see Section 5 of this provider manual.

**Adult Dental Services (4.8.5)**
In addition to dental services afforded to all HFS clients, Integrated Care Program Members have the value added benefits of an annual cleaning. Family Health Plan adults have the value added services of two exams and two cleanings per year.
Pregnant women are eligible for additional services, such as periodic exams, cleanings and deep cleanings.

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

**Well Child Visits and Periodicity Schedule (4.8.6)**

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 Healthcare providers are eligible for enhanced MCH add-on rates as specified on the HFS fee schedule.

**Additional Billable Services During Well Child Visits (4.8.7)**

Molina Healthcare 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 [http://www2.illinois.gov/hfs/MedicalProvider/Handbooks/Pages/HK200.aspx](http://www2.illinois.gov/hfs/MedicalProvider/Handbooks/Pages/HK200.aspx). 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.

**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.

**Objective Risk Assessment** - use CPT code 99420 for administration and interpretation of a health assessment 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.

**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 less 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.

**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.

**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.
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.

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.

Childhood Immunization Schedule (4.8.8)
Molina Healthcare 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](http://www.cdc.gov/vaccines/schedules/index.html).

Vaccines For Children (VFC) Program (4.8.9)
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. The detail regarding the specific vaccination defined by the CPT code must be reported on the claim so that an accurate immunization history is recorded by HFS and is available to the child’s PCP, parent/caretaker relative or guardian.

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.

If child presents for the sole purpose of getting an immunization and does not require seeing a physician, the minimal office visit and vaccine CPT codes should be billed. If vaccines are provided during a well-child visit, then the CPT code for well child visits and vaccine(s) should be billed.

I-CARE Immunization Database (4.8.10)
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 Healthcare 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.

**Interperiodic Screenings (4.8.11)**
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.

**BMI Assessments (4.8.12)**
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. If indicated, pertinent recommendation or plan of management consistent with the codes used is required.

**Weight Management Visits (4.8.13)**
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%) 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.

**Oral Screening and Dental Referral (4.8.14)**

An oral screening is part of the well child visit physical examination, but does not replace referral to a dentist. For children less 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 Healthcare provider dental benefits to Members though Avesis. Call (866) 857-8124 to locate a network dentist.

**Fluoride Varnishing (4.8.15)**

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 less 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/.

**Section 4.9 24 Hour Nurse Advice Line**

Members may call the Nurse Advice Line anytime they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, seven days a week, to assess symptoms and help make good healthcare decisions.

**HEALTHLINE**

(24-Hour Nurse Advice Line)
Phone: (888) 275-8750 (English) / (866) 648-3537 (Spanish)
TTY: (866) 735-2929 (English) / (866) 833-4703 (Spanish)
Molina Healthcare is committed to helping our Members:

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

The Nurse Advice Line registered nurses do not diagnose, they assess symptoms and guide the patient to the most appropriate level of care following specially designed algorithms unique to the Nurse Advice Line. The Nurse Advice Line may refer back to the PCP, a specialist, urgent care, ER, or 911. By educating patients, it facilitates appropriate use of the healthcare services.
Section 5
HEALTH MANAGEMENT PROGRAMS

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

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

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

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

Quality Improvement at (855) 866-5462
TTY at 711
Visit www.molinahealthcare.com

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

Section 5.1 Program Eligibility Criteria and Referral Source

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

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

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

Section 5.2 Provider Participation

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

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

Additional information on health management programs is available from the Molina Healthcare Quality Improvement Department toll free at (855) 866-5462.

Section 5.3 Motherhood Matters®

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

Although pregnancy itself is not considered a disease state, a significant percentage of pregnant females on Medicaid are found to be at moderate to high-risk for a disease condition for the mother, the baby or both. The Motherhood Matters® 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.

Motherhood Matters® Program Activities

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

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

Section 5.4 Breathe With Ease

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

Breathe With Ease Program Activities

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

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

**Additional Asthma Program Benefits:**

- **Clinical Practice Guidelines** – Molina Healthcare adopted the National Heart, Lung and Blood Institute (NHLBI) Asthma Guidelines
- **Asthma Registry** – Molina Healthcare established an asthma registry. The registry uses available claims and pharmacy information to identify and track asthma Members in the program
- **Asthma Newsletters** – Molina Healthcare distributes asthma newsletters to identified Members
- **Care Reminders and Age-Appropriate Tools** – Molina Healthcare provides individualized reminders and educational tools to Members with asthma
- **Asthma Education** – Asthma education is covered for all Molina Healthcare Members. We encourage providers to refer patients to these services, especially for newly diagnosed asthmatics or those having difficulty managing their disease
- **Smoking Cessation** – For information about the Molina Healthcare smoking cessation program or to enroll Members, please contact our Health Management Unit
- **Asthma Profiles** – We send PCPs a report or profile of patients with asthma. This shows specific patient utilization information of medication use, emergency department visits, and hospitalizations. We also request the PCP provide us with the names of Molina Healthcare asthma patients not included in the profile.

**Section 5.5 Healthy Living with Diabetes**

Molina Healthcare’s *Healthy Living with Diabetes* health management program is a collaborative team approach comprised of patient education, clinical case management and provider education. The team works closely with contracted practitioners in the identification, assessment and implementation of appropriate interventions for non-pregnant adults diagnosed with diabetes.

*Healthy Living with Diabetes* Includes:

- **Clinical Practice Guidelines** – Molina Healthcare adopted the American Diabetes Association (ADA) guidelines for diabetic care
- **Diabetes Registry** – Molina Healthcare established a diabetes registry. The registry uses available claims and pharmacy information to identify and track diabetic Members in the program
- Diabetes Newsletters – Molina Healthcare distributes newsletters to diabetic Members
- Care Reminders and Age-Appropriate Tools – Molina Healthcare provides individualized reminders and educational tools to Members with diabetes
- Diabetes Education – Diabetes education is covered for all Molina Healthcare Members. We encourage providers to refer patients to these services, especially for newly diagnosed diabetics or those having difficulty managing their disease
- Smoking Cessation – For information about the Molina Healthcare’s smoking cessation program or to enroll Members, please contact our Health Management Unit
- Diabetes Profiles – We will send the PCP a report or profile of patients with diabetes. This shows specific patient utilization information of medication use, emergency department visits, and hospitalizations. We also request the PCP provide us with the names of Molina Healthcare diabetic patients not included in the profile.

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

Section 5.6 Heart Healthy Living

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

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

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

- Clinical Practice Guidelines – Molina Healthcare adopted the NHLBI and the American Heart Association guidelines for cardiovascular care
- Cardiovascular Disease Registry – Molina Healthcare established a CVD registry. The registry uses available claims and pharmacy information to identify and track cardiovascular Members in the program
- Cardiovascular Disease Newsletters – Molina Healthcare distributes newsletters to CVD Members
- Care Reminders and Tools – Molina Healthcare provides individualized reminders and educational tools to Members with CVD
- Cardiovascular Disease Education – CVD education is covered for all Molina Healthcare Members. We encourage providers to refer patients to these services, especially for newly diagnosed heart disease or those having difficulty managing their disease
- Smoking Cessation – For information about the Molina Healthcare smoking cessation program or to enroll Members, please contact our Health Management Unit
• CVD Profiles – We will send the PCP a report or profile of patients with heart disease. This shows specific patient utilization information of medication use, emergency department visits, and hospitalizations. We also request the PCP provide us with the names of Molina Healthcare CVD patients not included in the profile.

To find out more information about the health management programs, please call (855) 866-5462.

**Healthy Living with COPD**

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

The Healthy Living with COPD Program Includes:

• Clinical Practice Guidelines – Molina Healthcare adopted the Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines for COPD care
• COPD Registry – Molina Healthcare established a COPD registry. The registry uses available claims and pharmacy information to identify and track COPD Members in the program
• COPD Newsletters – Molina Healthcare distributes newsletters to COPD Members
• Care Reminders and Appropriate Tools – Molina Healthcare provides individualized reminders and educational tools to Members with COPD
• COPD Education – COPD education is covered for all Molina Healthcare Members. We encourage providers to refer patients to these services, especially for newly diagnosed Members or those having difficulty managing their disease
• Smoking Cessation – For information about the Molina Healthcare smoking cessation program or to enroll Members, please contact our Health Management Unit
• COPD Profiles – We will send the PCP a report or profile of patients with COPD. This shows specific patient utilization information of medication use, emergency department visits, and hospitalizations. We also request the PCP provide us with the names of Molina Healthcare COPD patients not included in the profile.

To find out more information about the health management programs, please call (855) 866-5462.
Section 6
TRANSPORTATION

Section 6.1 Non-Emergency Transportation

Molina Healthcare provides free transportation to the following:

- Scheduled doctor’s appointments
- Pharmacy
- DME provider
- WIC office

Non-Emergency transportation is provided through Secure Transportation. If one of your ICP patients is in need of this service please have them call Secure directly at (844) 644-6354. For transportation for Family Health Plan Members, call Secure at (844) 644-6354 to schedule a ride.

For further assistance ICP Members can call (855) 766-5462. For Family Health Plan Members please call (855) 687-7861 TTY 711, and one of our Member Service Representatives will assist them with this request.

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

Section 6.2 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 in 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 7
PROVIDER RESPONSIBILITIES

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

Section 7.1 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 Healthcare must receive 30 days advance notice from the provider.

Section 7.2 Access to Care Standards

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

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

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<tr>
<th>Primary Care Practitioner (PCP)</th>
<th>Appointment Wait Time (Appointment Standards)</th>
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<td>Types of Care for Appointment</td>
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<tr>
<td>Emergency Care</td>
<td>Immediate</td>
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<td>Preventative Care Appointment</td>
<td>Within five weeks of request</td>
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<tr>
<td>Urgent</td>
<td>Within 24 hours (serious problem, not deemed emergency)</td>
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<tr>
<td>After Hours Care</td>
<td>After Hours Instruction / Standards</td>
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<tr>
<td>After Hours Emergency Instruction</td>
<td>“If this is an emergency, please hang up and dial 911.”</td>
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Section 7.3 Relocations and Additional Sites

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

Section 7.4 Site and Medical Record Keeping Practice Reviews

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

Section 7.5 Member Information and Marketing

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

- Distribute to its Members informational or marketing materials that contain false or misleading information
- Distribute to its Members marketing materials selectively within the service area
- Directly or indirectly conduct door-to-door, telephonic, or other cold-call marketing for Member enrollment
Section 8
MEDICAL MANAGEMENT

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

Section 8.1 Medical Necessity Review

In conjunction with regulatory guidance from the Centers for Medicare and Medicaid Services (CMS) and industry standards, Molina Healthcare only reimburses services provided to its Members that are medically necessary. Molina Healthcare 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 Healthcare Hospital or Provider Services Agreement.

Section 8.2 Clinical Information

Molina Healthcare 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 Healthcare 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 Healthcare Hospital or Provider Services Agreement.

Section 8.3 Prior Authorization

Molina Healthcare requires prior authorization for specified services as long as the requirement complies with Federal or State regulations and the Molina Healthcare Hospital or Provider Services 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 Healthcare prior authorization documents are updated annually and the current documents are posted on the Molina Healthcare website. Molina Healthcare has included at the end of this section of this manual links to the current Authorization Request form on the Molina Healthcare website. If using a different form the prior authorization request must include the following information:

- Member demographic information (name, date of birth, Molina Healthcare ID number, etc.)
- Provider demographic information (referring provider and referred to provider/facility)
- Requested service/procedure, including all appropriate procedural and diagnosis codes
- Clinical information sufficient to document the medical necessity of the requested service
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 Healthcare does not “retroactively” authorize services that require prior authorization.

Molina Healthcare will process any non-urgent requests within 10 days of receipt of request. Urgent requests will be processed within 72 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 Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting provider at (855) 866-5462.

Section 8.4 Requesting Prior Authorization

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

Fax: The Prior Authorization form can be faxed to Molina Healthcare at: (866) 617-4971. If the request is not on the form provided in this manual, be sure to send to the attention of the Health Care Services Department.

Phone: Prior Authorizations can be initiated by contacting Molina Healthcare’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

Section 8.5 Inpatient Management

Elective Inpatient Admissions (8.5.1)  
Molina Healthcare 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.

Emergent Inpatient Admissions (8.5.2)  
Molina Healthcare 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 Healthcare 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.

**Concurrent Inpatient Review (8.5.3)**
Molina Healthcare performs concurrent inpatient review in order to ensure patient safety, medical necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Performing these functions requires timely clinical information updates from inpatient facilities. Molina Healthcare will request updated original clinical records from inpatient facilities at regular intervals during a Member’s inpatient admission.

Molina Healthcare requires that requested clinical information updates be received by Molina Healthcare 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.

**Readmission Policy (8.5.4)**
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 Healthcare’s Quality Improvement Program to ensure that Molina Healthcare Members are receiving hospital care that is compliant with nationally recognized guidelines, Medicare regulations, State Medicaid regulations and CMS.

Molina Healthcare 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 Services Agreement between the Hospital and Molina Healthcare, Molina Healthcare will implement the readmission program pursuant to Medicare regulations and CMS for all Medicaid claims. Therefore in Illinois, Molina Healthcare 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 Healthcare 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 Services Agreement between the Hospital and Molina Healthcare.

**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.

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.

Section 8.6 Non-Network Providers

Molina Healthcare maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process in order to provide medical care for Molina Healthcare Members. Molina Healthcare 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 Healthcare.

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.

Section 8.7 Avoiding Conflict of Interest

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

Molina Healthcare does not reward providers or other individuals for issuing denials of coverage or care. Furthermore, Molina Healthcare never provides financial incentives to encourage authorization decision makers to make determinations that result in under-utilization. Also, we require our delegated medical groups/IPAs to avoid this kind of conflict of interest.

Section 8.8 Coordination of Care

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

**Continuity of Care and Transition of Members (8.8.1)**
It is Molina Healthcare’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 Healthcare at (855) 866-5462.

**Continuity and Coordination of Provider Communication (8.8.2)**
Molina Healthcare stresses the importance of timely communication between providers involved in a Member’s care. This is especially critical between specialists, including behavioral health providers, and the Member’s PCP. Information should be shared in such a manner as to facilitate communication of urgent needs or significant findings.

**Case Management (8.8.3)**
Molina Healthcare provides a comprehensive Case Management (CM) program to all Members who meet the criteria for services. The CM program focuses on procuring and coordinating the care, services, and resources needed by Members with complex issues through a continuum of care. Molina Healthcare adheres to Case Management Society of America Standards of Practice Guidelines in its execution of the program.

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

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

**Referral to Case Management (8.8.4)**
Members with high-risk medical conditions may be referred by their PCP or specialty care provider to the CM program. The case manager works collaboratively with all Members of the health care team, including the PCP, hospital UM staff, discharge planners, specialist providers, ancillary providers, the local Health Department and other community resources. The referral source provides the case manager with demographic, health care and social data about the Member being referred.
Members with the following conditions may qualify for case management and should be referred to the Molina Healthcare CM Program for evaluation:

- High-risk pregnancy, including Members with a history of a previous preterm delivery
- Catastrophic medical conditions (e.g. neoplasm, organ/tissue transplants)
- Chronic illness (e.g. asthma, diabetes, End Stage Renal Disease)
- 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 Healthcare at:

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

**PCP Responsibilities in Case Management Referrals (8.8.5)**
The Member's PCP is the primary leader of the health team involved in the coordination and direction of services for the Member. The case manager provides the PCP with reports, updates, and information regarding the Member's progress through the case management plan. The PCP is responsible for the provision of preventive services and for the primary medical care of Members.

**Case Manager Responsibilities (8.8.6)**
The case manager collaborates with all resources involved and the Member to develop a plan of care which includes a multidisciplinary action plan (team treatment plan), a link to the appropriate institutional and community resources, and a statement of expected outcomes. Jointly, the case manager, providers, and the Member are responsible for implementing the plan of care. Additionally the case manager:

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

**Health Education and Disease Management Programs (8.8.7)**
Molina Healthcare’s Health Education and Disease Management programs will be incorporated into the Member's treatment plan to address the Member's health care needs. Primary prevention programs may include smoking cessation and wellness.

**Emergency Services (8.8.8)**
Emergency services are covered on a 24-hour basis without the need for prior authorization for all Members experiencing an emergency medical situation.
Molina Healthcare of Illinois accomplishes this service by providing Utilization Management 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 Healthcare of Illinois, 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 Healthcare is prepared to authorize treatment to ensure that the patient is stabilized.

**Section 8.9 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.

At a minimum, each medical record must be legible and maintained in detail with the documentation outlined in Section 9 of this manual.

**Section 8.10 Medical Necessity Standards**

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

- Necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain
- Individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient’s needs
- Consistent with the generally accepted professional medical standards as determined by applicable Federal and State regulation, and not be experimental or investigational
- Reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide
- Furnished in a manner not primarily intended for the convenience of the Member, the Member’s caretaker, or the provider
The fact that a provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services Medically Necessary, a Medical Necessity or a Covered Service/Benefit.

Section 8.11 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 Healthcare’s vendor, CVS/Caremark Specialty Pharmacy.

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

Section 8.12 Prior Authorization Guidelines and Forms

Prior Authorization Guidelines and Prior Authorization Request Form

www.molinahealthcare.com/providers/il/medicaid/forms/Pages/fuf.aspx

Molina Healthcare Drug Formulary and Pharmacy Prior Authorization Request Form

www.molinahealthcare.com/providers/il/medicaid/drug/Pages/formulary.aspx
Section 9
QUALITY IMPROVEMENT

Section 9.1 Quality Improvement Department

Molina Healthcare maintains a Quality Improvement (QI) Department to work with Members and practitioners/providers in administering the Molina Healthcare Quality Improvement Program (QIP). You can contact the Molina Healthcare QI Department toll free at (855) 866-5462 or fax (855) 556-2074.

The address for mail requests is:

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

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

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

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

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

Section 9.2 Medical Records

Molina Healthcare requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to Members is consistently documented and that necessary information is readily available in the medical record. All entries will be indelibly added to the Member’s record. Molina Healthcare conducts a medical record review of all PCPs that includes the following components:

- Medical record confidentiality and release of medical records including behavioral health care records;
- Medical record content and documentation standards, including preventive healthcare;
- Storage maintenance and disposal; and
Process for archiving medical records and implementing improvement activities.

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

**Content (9.2.1)**
- 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 initialed by ordering practitioner/provider upon review with Lab results and other studies are filed in chart
- If patient was referred for consult, therapy, or ancillary service, a report or notation of result is noted at subsequent visit, or filed in medical record
- If the practitioner/provider admitted a patient to the hospital in the past twelve (12) months, the discharge summary must be filed in the medical record
- Advanced Directives are documented for those 18 years and older
- A release document for each Member authorizing Molina Healthcare to release medical information for facilitation of medical care
- Developmental screenings as conducted through a standardized screening tool
- Documentation of the age-appropriate screening that was provided in accordance with the periodicity schedule
- Documentation of a pregnant Member’s refusal to consent to testing for HIV infection and any recommended treatment

**Organization (9.2.2)**
- 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

Retrieval (9.2.3)
• The medical record is available to practitioner/provider at each encounter
• The medical record is available to Molina Healthcare for purposes of quality improvement
• The medical record is available to the Illinois Department of Healthcare and Family Services (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

Confidentiality (9.2.4)
• Medical Records are protected from unauthorized access
• Access to computerized confidential information is restricted
• Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information

Additional information on medical records is available from your local Molina Healthcare QI Department toll free at (855) 866-5462. See also Section 16 (HIPAA/Security) for additional information regarding the Health Insurance Portability and Accountability Act (HIPAA).

Section 9.3 Access to Care
Molina Healthcare is committed to timely access to care for all Members in a safe and healthy environment. Practitioners/providers are required to conform to the Access to Care appointment standards listed in Section 6 (Provider Responsibilities) to ensure that healthcare services are provided in a timely manner. The standards are based on 95% availability for emergency services and 80% or greater for all other services. The PCP or their designee must be available 24 hours a day, seven days a week to Members.

Appointment Access (9.3.1)
All practitioners/providers who oversee the Member’s healthcare are responsible for providing the following appointments to Molina Healthcare Members in the timeframes noted in Section 6 (Provider Responsibilities).

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 your local Molina Healthcare QI Department toll free at (855) 866-5462.

Office Wait Time (9.3.2)
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.
After Hours (9.3.3)
All practitioners must have back-up (on call) coverage after hours or during the practitioner’s absence or unavailability. Molina Healthcare requires practitioners to maintain a 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.

Appointment Scheduling (9.3.4)
Each practitioner must implement an appointment scheduling system. The following are the minimum standards:

- 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.
- A process for documenting missed appointments must be established. When a Member does not keep a scheduled appointment, it is to be noted in the Member’s record and the practitioner is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the medical record. If a second appointment is missed, the practitioner is to notify the Molina Healthcare Member Services Department, For ICP Member please call (855) 766-5462 (TTY/TDD: 711). For FHP Member please call (855) 687-786.
- 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.
- Special needs of Members must be accommodated when scheduling appointments. Including, but not limited to wheelchair-using Members and Members requiring language translation.
- A process for Member notification of preventive care appointments must be established, including, but not limited to immunizations and mammograms.
- 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.

Women’s Open Access (9.3.5)
Molina Healthcare allows Members the option to seek obstetrical and gynecological care from an obstetrician or gynecologist or PCP providing obstetrical and gynecological services. Member access to obstetrical and gynecological services is monitored to ensure Members have direct access to obstetrical and gynecological services.
Additional information on access to care is available under the Resources tab at:

- [www.molinahealthcare.com](http://www.molinahealthcare.com)
- Molina Healthcare QI Department toll free at (855) 866-5462
- Fax number (855) 556-2074.

### Monitoring Access Standards (9.3.6)

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

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

Additional information on access to care is available under the Resources tab at [www.molinahealthcare.com](http://www.molinahealthcare.com) or is available from your local Molina Healthcare QI Department toll free at (855) 866-5462.

### Section 9.4 Site and Medical Record Keeping Practice

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

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

### Adequacy of Medical Record Keeping Practices (9.4.1)

During the site-visit, Molina Healthcare discusses office documentation practices with the practitioner or practitioner’s staff. This discussion includes a review of the forms and methods used to keep the information in a consistent manner and include how the practice ensures confidentiality of records. Molina Healthcare assesses one medical/treatment records for orderliness of record and documentation practices. To ensure Member confidentiality, Molina Healthcare reviews a “blinded” medical/treatment record or a “model” record instead of an actual record.
Improvement Plans / Corrective Action Plans (CAP) (9.4.2)
If the medical group does not achieve the required compliance with the site review standards and/or the medical record keeping practices review standards, the Site Reviewer will do all of the following:

- Send a letter to the practitioner that identifies the compliance issues
- Send sample forms and other information to assist the practitioner to achieve a passing score on the next review
- Request the practitioner to submit a written CAP to Molina Healthcare within 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 Healthcare within 30 calendar days of notification by Molina Healthcare. The request for a CAP will be sent certified mail, return receipt requested. This improvement plan should be submitted by the office manager or practitioner and must include the expected time frame for completion of activities.

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

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

Section 9.5 Advance Directives (Patient Self-Determination Act)

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 Healthcare auditors will look for documented evidence of discussion between the practitioner/provider and the Member. Molina Healthcare will notify the provider via fax of an individual Member’s advance directives identified through care management, care coordination or case management. Providers are instructed to document the presence of an advance directive in a prominent location of the medical record. Auditors will also look for copies of the advance directive form. Advance directives forms are state specific to meet state regulations.

Each Molina Healthcare practitioner/provider must honor advance directives to the fullest extent permitted under law. PCPs must discuss advance directives with a Member and provide appropriate medical advice if the Member desires guidance or assistance. Molina Healthcare’s network practitioners and facilities are expected to communicate any objections they may have to a Member directive prior to service whenever possible. In no event may any practitioner/provider refuse to treat a Member or otherwise discriminate against a Member because the Member has completed an advance directive. CMS law gives Members the right to file a complaint with Molina Healthcare or the state survey and certification agency if
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 Healthcare will facilitate finding a new PCP or specialist as needed.

**Health Care Power of Attorney (9.5.1)**

Health Care Power of Attorney names another person to make medical decisions on behalf of Members when they cannot make the choices for themselves. It can include plans about the care a Member wants or does not want and include information concerning artificial life-support machines and organ donations. This form must be signed, dated and witnessed by a notary public to be valid.

**Living Will (9.5.2)**

A Living Will usually states if the Member wants to die naturally without life-prolonging care and can also include information about any medical care. A living will only applies if the Member has a terminal condition. This directive must be signed, dated and witnessed by two people who know the Member well but are not relatives, possible heirs, healthcare providers.

**Mental Health Treatment Preference Declaration (9.5.3)**

Mental Health Treatment Preference Declaration allows the Member to state if he/she wants to receive electroconvulsive treatment (ECT) or psychotropic medicine when he/she has a mental illness and is unable to make these decisions. It also allows Members to say whether they wish to be admitted to a mental health facility for up to 17 days of treatment. This advance directive expires three years from the date of signature. This directive must be signed, dated, and witnessed by two people who know the Member well but are not relatives, possible heirs, healthcare providers or employees of a healthcare facility in which the Member resides.

**When There Is No Advance Directive (9.5.4)**

The member’s family and practitioner will work together to decide on the best care for the Member based on information they may know about the Member’s end-of-life plans.

**Section 9.6 Monitoring Compliance with Standards**

Molina Healthcare 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 Healthcare’s standards may result in a CAP with a request the provider to submit a written CAP to Molina Healthcare 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.
Section 9.7 Quality Improvement Activities and Programs

Molina Healthcare maintains an active QIP. The QIP provides structure and key processes to carry out our ongoing commitment to improvement of care and service. The goals identified are based on an evaluation of programs and services; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

Clinical Practice Guidelines (9.7.1)
Molina Healthcare adopts and disseminates Clinical Practice Guidelines (CPGs) to reduce inter-practitioner/provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of medical literature and/or appropriate established authority. CPGs are reviewed annually and are updated as new recommendations are published.

Molina Healthcare CPGs include the following:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Hypertension
- ADHD
- Heart Failure in Adults
- Management of Obesity for Adults
- Diabetes

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

Preventive Health Guidelines (9.7.2)
Molina Healthcare provides coverage of diagnostic preventive procedures based on recommendations published by the Institute for Clinical Systems Improvements (ICSI) and in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines. Molina Healthcare 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 with each release by ICSI and are 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 Healthcare provider newsletter.

Cultural and Linguistic Services (9.7.3)

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

24 Hour Access to Interpreter

Practitioners/providers may request interpreters for Members whose primary language is other than English by calling Molina Healthcare’s Member Services Department. For ICP Members please call (855) 766-5462. For FHP Members please call (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 Healthcare is available to assist you in notifying Members of their right to an interpreter. All counseling and treatment done via an interpreter should be noted in the medical record by stating that such counseling and treatment was done via interpreter services. Practitioners/providers should document who provided the interpretation service. That information could be the name of their internal staff or someone from a commercial vendor such as Language Line. Information should include the interpreter’s name, operator code number and vendor.

Face-to-Face Interpretation

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

Section 9.8 Measurement of Clinical and Service Quality

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

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

Molina Healthcare’s most recent results can be obtained from your local Molina Healthcare QI Department toll free at (855) 866-5462 or fax (855) 556-2074.

Contracted Providers and Facilities must allow Molina Healthcare to use its performance data collected in accordance with the provider’s or facility’s contract. The use of performance data may include, but is not limited to, the following: (1) development of quality improvement activities; (2) public reporting to consumers; (3) preferred status designation in the network; (4) and/or reduced Member cost sharing.

**HEDIS® (9.8.1)**
Molina Healthcare utilizes 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 aspects including immunizations, women’s health screening, pre-natal visits, diabetes care, and cardiovascular disease.

HEDIS® results are used in a variety of ways. They are the measurement standard for many of Molina Healthcare’s clinical quality improvement activities and health improvement programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the success of these programs.

Selected HEDIS® results are provided to regulatory and accreditation agencies as part of our contracts with these agencies. The data are also used to compare to established health plan performance benchmarks.

**CAHPS® (9.8.2)**
CAHPS® is the tool used by Molina Healthcare to summarize Member satisfaction with the healthcare and service they receive. CAHPS® examines specific measures, including getting needed care, getting care quickly, how well doctors communicate, health promotion and education, coordination of care and customer service. The CAHPS® survey is administered annually in the spring to randomly selected Members by 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 Healthcare’s quality improvement activities and are used by external agencies to help ascertain the quality of services being delivered.

**Provider Satisfaction Survey (9.8.3)**
Recognizing that HEDIS® and CAHPS® both focus on Member experience with healthcare practitioners/providers and health plans, Molina Healthcare conducts a Provider Satisfaction Survey annually. The results from this survey are very important to Molina Healthcare, as this is one of the primary
methods we use to identify improvement areas pertaining to the Molina Healthcare provider network. The survey results have helped establish improvement activities relating to Molina Healthcare’s specialty network, inter-provider communications, and pharmacy authorizations. This survey is fielded to a random sample of practitioners/providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

**Effectiveness of Quality Improvement Initiatives (9.8.4)**
Molina Healthcare monitors the effectiveness of clinical and service activities through metrics selected to demonstrate clinical outcomes and service levels. The plan’s performance is compared to that of available national benchmarks indicating “best practices.” Results of these measurements guide activities for the successive periods.

**Section 9.9 Health, Safety and Welfare**
As a provider and participant in Molina Healthcare’s quality improvement processes, you have a right to have access to information about Molina Healthcare’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 Healthcare 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.

**Section 9.10 Quality of Care Issues**
Quality of care (QOC) issues may be identified by providers, Members, regulatory agencies or any department within Molina Healthcare, including but not limited to, Member Services, Grievance, Regulatory Affairs, Provider Relations, Risk Management, Health Care Services (Utilization Management (UM), Case Management (CM), Disease Management (DM), Quality Improvement (QI) or the Medical Director(s).

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

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

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

Section 9.11 Abuse, Neglect and Exploitation

A critical incident is any serious or traumatic event that causes, or can cause, physical or mental harm or harm to the well-being of a person. Critical Incidents are classified as abuse, neglect, exploitation, or other types which fall outside of those categories. Illinois’ investigative agencies are designed to protect elders, vulnerable adults and children from abuse, neglect or exploitation. Agencies such as the Department of Children and Family Services, the Department on Aging (DOA), the Department of Human Services Office of Inspector General, and the Illinois Department of Health and Family Services (HFS) have defined processes for ensuring victims of abuse, neglect or exploitation are safe. 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 Healthcare 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 [Adult Protective Services Hotline](866) 800-1409 (VOICE), (888) 206-1327 (TTY) for victims aged 18-59 with a disability and victims aged 60 years and older who reside in the community.

Reports of abuse, neglect and exploitation should be made to the [Illinois Department of Children and Family Services](800) 252-2873 for victims under the age of 18.

Reports of abuse, neglect and exploitation should be made to the Illinois Department of Public Health (IDPH) [Nursing Home Hotline](800) 252-4343 for complaints regarding incidents in hospitals, nursing facilities, and home health agencies.

Reports of abuse, neglect and exploitation of Members residing in Supportive Living Facilities (SLF) should be made to the [HFS SLF Complaint Hotline](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/TTY for victims aged 18-59 receiving mental health or Developmental Disability services in DHS operated, licensed, certified or funded programs.
Molina Healthcare may immediately terminate or it may suspend, pending investigation, the participation status of a provider who, in the opinion of Molina Healthcare’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 Healthcare 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 Healthcare reporting to regulatory agencies. Please refer to the Credentialing, Appeal Rights and Fair Hearing sections of this manual for further information.
Section 10
CLAIMS

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

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

Section 10.1 Claim Submission
Claims may be submitted to Molina Healthcare with appropriate documentation by mail or filed electronically (EDI) for CMS-1500 and UB-04 claims. For Members assigned to a delegated medical group/IPA that processes its own claims, please verify the “Remit To” address on the Member’s Molina Healthcare ID card. Providers billing Molina Healthcare directly should send claims to:

Molina Healthcare of Illinois, Inc.
P.O. Box 540
Long Beach, CA 90801

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

Providers must use good faith effort to bill Molina Healthcare for services with the most current CMS approved diagnostic and procedural coding available as of the date the service was provided, or for inpatient facility claims, the date of discharge. The following information must be included on every claim:

Institutional Providers (10.1.1)
- The completed UB 04 data set or its successor format adopted by the National Uniform Billing Committee (NUBC), submitted on the designated paper or electronic format as adopted by the NUBC.
- Entries stated as mandatory by NUBC and required by federal statute and regulations and any state designated data requirements included in statutes or regulation.

Physicians and Other Professional Providers (10.1.2)
- The Centers for Medicare and Medicaid Services (CMS) Form 1500 or its successor adopted by the National Uniform Claim Committee (NUCC) submitted on the designated paper or electronic format.
- Entries state as mandatory by NUCC and required by federal statute and regulation and any state designated data requirements included in statutes or regulations.
Services Provided by Resident or Intern (10.1.3)
When an intern or a resident provides medical services to a participant, the teaching physician will be reimbursed. The teaching physician must:
- Be personally involved in the patient’s care
- 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 Healthcare, 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 Healthcare 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:
- Identifies the level of supervision for each year of residency
- Describes specific situations where residents may and may not function independently
- 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 Healthcare 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 the topic.

National Provider Identifier (NPI) (10.1.4)
Providers must report any changes in their NPI or subparts to Molina Healthcare within 30 calendar days of the change.

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

Electronic Claim Submission (10.1.5)
Molina Healthcare also accepts electronic claim submissions for both claims and encounters using the CMS-1500 and UB-04 claim types. Please use Molina Healthcare’s Electronic Payor ID number –20934. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure claims are received for processing in a timely manner.

When your claims are filed electronically:
You should receive an acknowledgement from your current clearinghouse
You should receive an acknowledgement from Emdeon within two business days of your transmission
You should contact your local clearinghouse representative if you experience any problems with your transmission
For any direct submissions to Molina Healthcare you should receive an acknowledgement of your transmission

Section 10.2 Timely Claim Filing

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

Section 10.3 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 Section 11 (Fraud and Abuse) of this manual for more information.

Section 10.4 Timely Claim Processing

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

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

Section 10.5 Claim Editing Process

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

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

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

Section 10.6 Coordination of Benefits and Third Party Liability

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

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

Section 10.7 Corrected Claims

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

Molina Healthcare of Illinois, Inc.
P.O. Box 540
Long Beach, CA 90801

Section 10.8 Claims Disputes and Adjustments

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

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

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

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

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

The Provider will be notified of Molina Healthcare of Illinois’ decision in writing within 60 calendar days of receipt of the Claims Dispute/Adjustment request. Providers may not “bill” the Member when a denial for covered services is upheld per review. A redetermination request, which differs from “Provider Dispute/Adjustment” request, must be submitted within 120 days of the original RA from Molina Healthcare in order to be considered. Providers may request a claim redetermination when the claim was incorrectly denied as a duplicate or due to claims examiner or data-entry error.

Section 10.9 Overpayment, Incorrect Payments and Refund Requests

If, as a result of retroactive review of coverage decisions or payment levels, Molina Healthcare determines that it has made an overpayment to a provider for services rendered to a Member, it will make a claim for such overpayment. Molina Healthcare will not reduce payment to that provider for other services unless the provider agrees to the reduction or fails to respond to Molina Healthcare’s claim as required in this subsection.

A provider shall pay a claim for an overpayment made by a Molina Healthcare which the provider does not contest or deny within the specified number of days on the refund request letter mailed to the provider.

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

Section 10.10 Billing Members

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

Section 10.11 Encounter Data

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

Encounter data must be submitted once per month, and must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I – Institutional, 837P – Professional, and 837D – Dental. Data must be submitted with claims level detail for all non-institutional services provided. For institutional services, only those services covered by Molina Healthcare should be reported. Molina Healthcare shall have a comprehensive automated and integrated encounter data system capable of meeting these requirements.

Molina Healthcare will create Molina Healthcare’s 837P, 837I, and 837D Companion Guides with the specific submission requirements available to providers.
Section 11
HOSPITALS

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

Section 11.1 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 Healthcare.

Members accessing the emergency department inappropriately will be contacted by Molina Healthcare Case Managers whenever possible to determine the reason for using emergency services. Case Managers will also contact the PCP to ensure that Members are not accessing the emergency department because of an inability to be seen by the PCP.

Section 11.2 Admissions

Hospitals are required to notify Molina Healthcare 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.

Section 11.3 Claim Submission

Claims must be submitted in accordance with the guidelines and processes set forth in Section 10 (Claims) of this manual.

Value Code 54 for Birth Weight (11.3.1)

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.
Section 11.4 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.

The MCO Hospital Access Program will provide funding for MCOs to provide payment to hospitals to assure access to hospital care to Medicaid enrollees. The Illinois Hospital Association (IHA) has agreed to assist with administering the MCO Hospital Access Program and to receive payments from the MCOs on behalf of the hospitals that have designated IHA to do so by entering into a Hospital Participation Agreement with the MCOs.

Copies of the MCO Hospital Access Program documents required to enter into agreement with Molina Healthcare are posted on the Forms page at www.MolinaHealthCare.com. The forms required to be completed are:

- MCO Hospital Access Program Hospital Participation Agreement
- W-9
- Provider Profile and EFT Registration Form.
Section 12
FRAUD, WASTE AND ABUSE

Molina Healthcare of Illinois 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 Healthcare of Illinois 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 Healthcare of Illinois 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 Healthcare of Illinois.

Section 12.1 Mission Statement

Molina Healthcare of Illinois 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 Healthcare of Illinois 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.

Section 12.2 Regulatory Requirements

Federal False Claims Act (12.2.1)
The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. Government for payment.

The term “knowing” is defined to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or
- Acts in reckless disregard of the truth or falsity of the information in a claim.

The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted.

Deficit Reduction Act (12.2.2)
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 Healthcare of Illinois 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 Healthcare of Illinois, 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 Healthcare will take steps to monitor Molina Healthcare of Illinois contracted providers to ensure compliance with the law.

Definitions of Fraud, Waste and Abuse (12.3)

Fraud
Fraud is 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 occurs when provider practices 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)

Examples of Fraud, Waste and Abuse by a Provider (12.4)

• 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 Healthcare of Illinois 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)

**Section 12.5 Review of Provider**

The Credentialing Department government is responsible for monitoring practitioners through the various 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.
Section 12.6 Provider/Practitioner Education

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

The Molina Healthcare of Illinois Provider Services 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.

Section 12.7 Review of Provider Claims and Claims System

Molina Healthcare 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 preformed as authorized.

Molina Healthcare of Illinois 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.

Section 12.8 Reporting Fraud, Waste and Abuse

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina Healthcare 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 Healthcare 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 Healthcare AlertLine can be reached toll free at (866) 606-3889 or you may use the service’s website to make a report at any time at: https://molinahealthcare.alertline.com

You may also report cases of fraud, waste or abuse to the Molina Healthcare of Illinois Compliance Department. You have the right to have your concerns reported anonymously without fear of retaliation.

Section 12.9 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
Section 13
CREDENTIALING AND RE-CREDENTIALING

The Credentialing Program strives to ensure the Molina Healthcare network consists of quality practitioners/providers who meet clearly defined criteria and standards. It is the objective of Molina Healthcare to provide superior health care to the community. The decision to accept or deny a credentialing applicant is based upon primary source verification, recommendation of peer practitioners/providers and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under state and federal law. The Credentialing Program has been developed in accordance with state and federal requirements and accreditation guidelines. In accordance with those standards, Molina Healthcare Members will not be referred and/or assigned to you until the credentialing process has been completed.

Section 13.1 Criteria for Participation in the Molina Healthcare Network

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

To remain eligible for participation practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentation provided by Molina Healthcare.

Molina Healthcare reserves the right to exercise discretion in applying any criteria and to exclude practitioners who do not meet the criteria. Molina Healthcare 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 that such waiver is necessary to meet the needs of Molina Healthcare and the community it serves. The refusal of Molina Healthcare to waive any requirement shall not entitle any practitioner to a hearing or any other rights of review.

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

- Practitioner must practice, or plan to practice within 90 calendar days, within the area served by Molina Healthcare.
- All providers, including ancillary providers, (i.e. vision, pharmacy, etc.), will apply for enrollment in the Medicaid program. Providers are required to have an NPI or an Administrative Provider Identification Number (APIN).
- Practitioner must complete and submit to Molina Healthcare a credentialing application. The application must be entirely complete. The practitioner must sign and date that application attesting that their application is complete and correct within 180 calendar days of the credentialing decision. If Molina Healthcare or the Credentialing Committee requests any additional information or clarification the practitioner must supply that information in the time-frame requested.
- Practitioner must have a current, valid license to practice in their specialty in every state in which they will provide care for Molina Healthcare Members.
- If applicable to the specialty, practitioner must hold a current and unrestricted federal Drug Enforcement Agency (DEA) certificate and Controlled Substance Certification or Registration. If a practitioner has never had any disciplinary action taken related to his/her DEA or CDS and chooses not to have a DEA or CDS, the practitioner may be considered for network participation if they submit a written prescription...
plan describing the process for allowing another practitioner with a valid DEA or CDS certificate to write all prescriptions. If a practitioner does not have a DEA because of disciplinary action including but not limited to being revoked or relinquished, the practitioner is not eligible to participate in the Molina Healthcare network.

- Practitioners will only be credentialed in an area of practice in which they have adequate education and training as outlined below. Therefore practitioners must confine their practice to their credentialed area of practice when providing services to Molina Healthcare Members.
- Practitioners must have graduated from an accredited school with a degree required to practice in their specialty.
- Oral Surgeons and Provider (MDs, DOs) must have satisfactorily completed a training program from an accredited training program in the specialty in which they are practicing. Molina Healthcare only recognizes training programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must have completed a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA).
- Board certification in the specialty in which the practitioner is practicing is preferred but not required. Initial applicants who are not Board Certified may be considered for participation only if they have satisfactorily completed a training program from an accredited training program in the specialty in which they are practicing. Molina Healthcare recognizes Board Certification only from the following Boards:
  - American Board of Medical Specialties (ABMS)
  - American Osteopathic Association (AOA)
  - American Board of Podiatric Surgery (ABPS)
  - American Board of Podiatric Medicine (ABPM)
  - American Board of Oral and Maxillofacial Surgery
- Practitioners who are not Board Certified and have not completed a training program from an accredited training program are only eligible to be considered for participation as a General Practitioner in the Molina Healthcare network. To be eligible, the practitioner must have maintained a Primary Care practice in good standing for a minimum of the most recent five years without any gaps in work history.
- Practitioner must supply a minimum of 5-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If the practitioner has practiced fewer than 5-years from the date of Credentialing, the work history starts at the time of initial licensure. Experience practicing as a non-physician health professional (e.g. registered nurse, nurse practitioner, clinical social worker) within the 5-years should be included. If Molina Healthcare determines there is a gap in work history exceeding six-months, the practitioner must clarify the gap either verbally or in writing. Verbal communication must be appropriately documented in the credentialing file. If Molina Healthcare determines there is a gap in work history that exceeds one-year, the practitioner must clarify the gap in writing.
- Practitioner must supply a full history of malpractice and professional liability claims and settlement history. Documentation of malpractice and professional liability claims and settlement history is requested from the practitioner on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.
- Practitioner must disclose a full history of all license actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations and non-renewals. Practitioner must also disclose any history of voluntarily relinquishing, withdrawing, or failure to proceed with an application in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.
• At the time of initial application, the practitioner must not have any pending or open investigations from any state or governmental professional disciplinary body\(^1\). This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.

• Practitioner must disclose all Medicare and Medicaid sanctions. Practitioner must disclose all debarments, suspensions, proposals for debarments, exclusions or disqualifications under the no procurement common rule, or when otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.

• Practitioner must not be currently sanctioned, excluded, expelled or suspended from any state or federally funded program including but not limited to the Medicare or Medicaid programs.

• Practitioner must have current professional malpractice liability coverage with limits that meet Molina Healthcare criteria. This coverage shall extend to Molina Healthcare Members and the practitioners activities on Molina Healthcare’s behalf.

• Practitioner must disclose any inability to perform essential functions of a practitioner in their area of practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.

• Practitioner must disclose if they are currently using any illegal drugs/substances. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner. If a practitioner discloses any issues with substance abuse (e.g. drugs, alcohol) the practitioner must provide evidence of either actively and successfully participating in a substance abuse monitoring program or successfully completing a program.

• Practitioner must disclose if they have ever had any criminal convictions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.

• Practitioner must not have been convicted of a felony or pled guilty to a felony for a healthcare related crime including but not limited to healthcare fraud, patient abuse and the unlawful manufacture distribution or dispensing of a controlled substance.

• Practitioner must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the practitioner has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.

• Physicians (MD, DO), Primary Care Practitioners, Nurse Midwives, Oral Surgeons, Podiatrists and/or those practitioners dictated by state law, must have admitting privileges in their specialty. If a practitioner chooses not to have admitting privileges, the practitioner may be considered for network participation if they have a plan for hospital admission by using a Hospital Inpatient Practitioners not able to practice independently according to state law must have a practice plan with a supervising physician approved by the state licensing agency. The supervising physician must be contracted and credentialed with Molina Healthcare.

• Practitioner’s currently listed on the Medicare Opt-Out Report may not participate in the Molina Healthcare network for any Medicare line of business.

• If applicable to the specialty, practitioner must have a plan for shared call coverage that includes 24-hours a day, seven days per week and 365 days per year. The covering practitioner(s) must be qualified to assess over the phone if a patient should immediately seek medical attention or if the patient can wait to be seen on the next business day. All Primary Care Practitioners must have 24-hour coverage.

Physicians practicing in Dermatology, Occupational Medicine, Pain Medicine, Physical Medicine and

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\(^1\) If a practitioner’s application is denied solely because a practitioner has appending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the practitioner may reapply as soon as practitioner is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action, or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one year from the date of original denial.
Rehabilitation, Sleep Medicine, Telemedicine, Sports Medicine, Urgent Care and Wound Management are not required to have 24-hour coverage.

- Molina Healthcare may determine, in its sole discretion that a practitioner is not eligible to apply for network participation if the practitioner is an employee of a practitioner or an employee of a company owned in whole or in part by a practitioner, who has been denied or terminated from network participation by Molina Healthcare, who is currently in the Fair Hearing Process, or who is under investigation by Molina Healthcare. Molina Healthcare also may determine, in its sole discretion that a practitioner cannot continue network participation if the practitioner is an employee of a practitioner or an employee of a company owned in whole or in part by a practitioner, who has been denied or terminated from network participation by Molina Healthcare. For purposes of this criteria, a company is “owned” by a practitioner when the practitioner has at least 5% financial interest in the company, through shares or other means.

- Practitioners denied by the Credentialing Committee are not eligible to reapply until one year after the date of denial by the Credentialing Committee. At the time of reapplication, practitioner must meet all criteria for participation outlined above.

- Practitioners terminated by the Credentialing Committee or terminated from the network for cause are not eligible to reapply until five years after the date of termination. At the time of reapplication, practitioner must meet all criteria for participation as outlined above.

- Practitioners denied or terminated administratively are eligible to reapply for participation anytime as long as the practitioner meets all criteria for participation above.

**Burden of Proof (13.1.1)**

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

**Termination and Reinstatement (13.1.2)**

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

If a practitioner is given administrative termination for reasons beyond Molina Healthcare’s control (e.g., the practitioner failed to provide complete credentialing information), and is then reinstated within 30 calendar days, Molina Healthcare may recredential the practitioner as long as there is clear documentation that the practitioner was terminated for reasons beyond Molina Healthcare’s control and was recredential and reinstated within 30 calendar days of termination. Molina Healthcare must initially credential the practitioner if reinstatement is more than 30 calendar days after termination.

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

**Terminating with a Delegate - Contracting with Molina Healthcare Directly (13.1.3)**
Practitioners credentialed by a delegate who terminate their contract with the delegate and want to contract with Molina Healthcare directly must be credentialed by Molina Healthcare within six-months of the practitioner’s termination with the delegate. If the practitioner has a break in service more than 30 calendar days, the practitioner must be initially credentialed prior to reinstatement.

**Section 13.2 Credentialing Application**

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

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

**Inability to perform essential functions and illegal drug use (13.2.1)**
An inquiry regarding illegal drug use and inability to perform essential functions may vary. Practitioners may use language other than “drug” to attest they are not presently using illegal substances. Molina Healthcare may accept more general or extensive language to query practitioners about impairments; language does not have to refer exclusively to the present, or only to illegal substances. Once the application is received, Molina Healthcare will complete all the verifications as outlined in the Molina Healthcare Credentialing Program Policy. In order for the application to be deemed complete, the practitioner must produce adequate information to prove he/she meets all criteria for initial participation or continued participation in the Molina Healthcare network. All fields within the application must be completed, all required attachments must be included, detailed explanations must be provided to all affirmative answers on the attestation questions and any additional information requested by Molina Healthcare must be provided.

If the practitioner does not provide the information necessary to complete the application process in the time period requested, the application will be deemed incomplete and Molina Healthcare will discontinue processing of the application. This will result in an administrative denial or administrative termination from the Molina Healthcare network. Practitioners who fail to provide proof of meeting the criteria or fail to provide a complete credentialing application do not have the right to submit an appeal.
At the completion of the application and primary source verification process, each credentialing file is quality reviewed to ensure completeness. During this quality review process each credentialing file is assigned a level based on established guidelines. Credentialing files assigned a level 1 are considered clean credentialing files and the Medical Director(s) responsible for credentialing has the authority to review and approve them. Credentialing files assigned a level 2 are reviewed by the Molina Healthcare Credentialing Committee.

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

**Section 13.3 Process for Making Credentialing Decisions**

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

Molina recredentials its practitioners at least every thirty-six (36) months. Approximately six months prior to the recredentialing due date, the practitioners application will be downloaded from CAQH (or a similar NCQA accepted online applications source), or a request will be sent to the practitioner requesting completion of a recredentialing application.

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

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

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

If the practitioner does not provide the information necessary to complete the application process in the time period requested, the application will be deemed incomplete and Molina will discontinue processing of the application. This will result in an administrative denial or administrative termination from the Molina network. Practitioners who fail to provide proof of meeting the criteria or fail to provide a complete credentialing application do not have the right to submit an appeal.
At the completion of the application and primary source verification process, each credentialing file is quality reviewed to ensure completeness. During this quality review process each credentialing file is assigned a level based on established guidelines. Credentialing files assigned a level 1 are considered clean credentialing files and the Medical Director(s) responsible for credentialing has the authority to review and approve them. Credentialing files assigned a level 2 are reviewed by the Molina Credentialing Committee.

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

Section 13.4 Process for Delegating Credentialing and Recredentialing

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

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

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

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

Section 13.5 Non-Discriminatory Credentialing and Recredentialing

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

Section 13.6 Notification of Discrepancies in Credentialing Information

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

Section 13.7 Notification of Credentialing Decisions

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

Section 13.8 Confidentiality and Immunity

Information regarding any practitioner 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 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 practitioner’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 practitioner’s or provider’s provision of patient care services. By providing patient care services at Molina Healthcare, a practitioner or provider:

- Authorizes representatives of Molina Healthcare to solicit, provide, and act upon information bearing on the practitioner’s or 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 Healthcare Membership and the continuation of such Membership, and to 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 or Practitioner;
- Actions reducing, suspending, terminating or revoking a practitioner’s and 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 Healthcare operations and actions relating to practitioner and provider conduct.

Immunity from Liability for Action Taken (13.8.1)
No representative shall be liable to a practitioner or 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 (13.8.2)
No representative or third parties shall be liable to a practitioner or 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 practitioner or 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 (13.8.3)
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 Healthcare. The Director in charge of Credentialing grants access to electronic credentials files only as necessary to complete credentialing work or as required by law. Access to these documents are restricted to authorized staff, Credentialing Committee Members, peer reviewers and reporting bodies as authorized by the Credentialing Committee or the Governing Board of Molina Healthcare. Each person is given a unique user ID and password. It is the strict policy of Molina Healthcare that employees keep their passwords confidential and never share their passwords with anyone. All Credentialing employees are prompted to change their passwords into the system every three-months.

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

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

Section 13.9 Practitioners Rights during the Credentialing Process
Practitioners have the right to review their credentials file at any time. Practitioners are notified of their right in a letter sent to them at the time the initial or recredentialing application is received.

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

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

Section 13.10 Practitioners Right to Correct Erroneous Information

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

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

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

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

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

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

Section 13.11 Practitioners Right to be Informed of Application Status
Practitioners have a right, upon request, to be informed of the status of their application. Practitioners applying for initial participation are sent a letter when their application is received by Molina Healthcare and are notified of their right to be informed of the status of their application in this letter.

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

Section 13.12 Credentialing Committee

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

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

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

Committee Composition (13.12.1)
The Medical Director chairs the Credentialing Committee and appoints all Credentialing Committee Members. Each Member is required to meet all of Molina Healthcare's credentialing criteria. Credentialing Committee Members must be current representatives of Molina Healthcare’s practitioner network. The Credentialing Committee representation includes at least five practitioners. These may include practitioners from the following specialties:

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

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

Committee Members Roles and Responsibilities (13.12.2)
Committee Members participate in and support the functions of the Credentialing Committee by attending meetings, providing input and feedback and overall guidance of the Credentialing Program.

Review/approve credentialing program policy and related policies established by Molina Healthcare Healthcare on an annual basis, or more often as deemed necessary.

Review and consider each applicant’s information based on criteria and compliance requirements. The Credentialing Committee votes to make final decisions regarding credentialing determinations and disciplinary actions.

Conduct ongoing monitoring of those practitioners approved to be monitored on a “watch status”

Access clinical peer input when discussing standards of care for a particular type of practitioner when there is no committee Member of that specialty.

Ensure credentialing activities are conducted in accordance with Molina Healthcare’s Credentialing Program.

Review quality improvement findings as part of the recredentialing and the ongoing monitoring process.

Section 13.13 Excluded Practitioners

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

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

Section 13.14 Practitioners/Providers Opting Out of Medicare

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

Section 13.15 Ongoing Monitoring of Sanctions

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

Medicare and Medicaid Sanctions (13.15.1)

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

Molina Healthcare also monitors every month for state Medicaid sanctions/exclusions/terminations through each state’s specific Program Integrity Unit (or equivalent). If a practitioner is found to be sanctioned/excluded/terminated from any state’s Medicaid program, the practitioner will be terminated in every state where they are contracted with Molina Healthcare and for every line of business.

Sanctions or limitations on licensure (13.15.2)
Molina Healthcare monitors for sanctions or limitations against licensure between credentialing cycles for all network practitioners. All practitioners with identified sanctions or limitations on license in the ongoing monitoring process will be immediately placed into the full credentialing process and will be recredentialed early. The practitioner must provide all necessary information to complete the recredentialing process within the requested time-frames or the practitioner will be administratively terminated from the network. The complete recredentialing file will be reviewed at the next scheduled Credentialing Committee meeting for a determination.

Continuous Query (Proactive Disclosure Service) (13.15.3)
Molina Healthcare registers all network practitioners with the NPDB Continuous Query program.

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

Member Complaints/Grievances (13.15.4)
Each Molina Healthcare health plan has a process in place to investigate practitioner-specific complaints from Members upon their receipt. Molina Healthcare evaluates both the specific complaint and the practitioner’s history of issues, if applicable. The history of complaints is evaluation for all practitioners at least every six months.

Adverse Events (13.15.5)
Each Molina Healthcare health plan has a process in place for monitoring practitioner 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 practitioner. Molina Healthcare monitors for adverse events at least every six months.

System for Award Management (SAM) (13.15.6)
Molina Healthcare monitors the SAM once per month to ensure practitioners have not been sanctioned. If a Molina Healthcare network provider is found with a sanction, the practitioner’s contract is terminated effective the same date the sanction was implemented.

Medicare Opt-Out (13.15.7)
Practitioner’s participating in Medicare must not be listed on the Medicare Opt-Out report. Molina Healthcare reviews the quarterly opt out reports released from the appropriate Medicare financial intermediary showing all of the practitioners who have chosen to Opt-Out of Medicare. These reports are reviewed within 30 calendar days of their release. If a physician or other practitioner opts out of Medicare, that physician or other practitioner may not accept Federal reimbursement for a period of 2 years. These provider contracts will be immediately terminated for the Molina Healthcare Medicare line of business.
Section 13.16 Program Integrity (Disclosure of Ownership/Controlling Interest)

Medicaid Managed Care Health Plans are required to collect specific information from network providers prior to contracting and during credentialing 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 42 CFR §455. The categorical details required and collected at all initial and recredentialing must be current and are as follows:

- Detailed identifying information for any individual who has ownership or controlling interest in the individual/entity being contracted if that individual has a history of criminal activity related to Medicaid, Medicare, or Title XX services (see 42 CFR §455.106).
- Detailed identifying information for all individuals who exercise operational or managerial control either directly or indirectly over daily operations and activities (see 42 CFR §455.101).
- Detailed identifying information for all individuals or entities that have a 5% or more ownership or controlling interest in the individual/entity being contracted (see 42 CFR§455.104).

Section 13.17 Office Site and Medical Record Keeping Practices Review

A review of office sites where you see Molina Healthcare Members may be required. This review may be scheduled as soon as the Credentialing Department receives your application. This may also include a review of your medical record keeping practices. A passing score is required to complete the application process. Your cooperation in working with the site review staff and implementing any corrective action plans will expedite a credentialing decision.

Office site and medical record keeping reviews may also be initiated if any Member complaints are received regarding the physical accessibility, physical appearance or adequacy of waiting room and examining room space.

Section 13.18 Range of Actions, Notification to Authorities and Practitioner Appeal Rights

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

Range of actions available (13.18.1)

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

- Monitor on a Watch Status
- Require formal corrective action
- Denial of network participation
- Termination from network participation
- In cases where the Medical Director determines the circumstances pose an immediate risk to patients, a practitioner may be summarily suspended from participation in the network, without prior notice, pending review and investigation of information relevant to the case.
This applies to all practitioners who are contracted by Molina Healthcare. These actions do not apply to applicants who do not meet basic conditions of participation and are ineligible for participation. If at any point a practitioner fails to meet the minimum standards and criteria for credentialing or fails to meet performance expectations with regard to quality of patient care the Credentialing Committee may act to implement one of these actions. Termination may be taken after reasonable effort has been made to obtain all the facts of the matter and the practitioner may be given the opportunity to appeal this decision.

**Criteria for Denial or Termination Decisions by the Credentialing Committee (13.18.2)**

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

1. The practitioner’s professional license in any state has 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.
2. Practitioner 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 practitioner’s acts, omissions or conduct.
3. Practitioner has any pending statement of charges, notice of proposed disciplinary actions, notice of agency action or the equivalent from any state or governmental professional disciplinary body which based on the judgment of the Credentialing Committee establishes an immediate potential risk to the quality of care or service delivered by the practitioner to Molina Healthcare Members.
4. Practitioner has or has ever had any restrictions, probations, limitations, conditions, suspensions or revocations on their federal Drug Enforcement Agency (DEA) certificate or Controlled Substance Certification or Registration.
5. Practitioner has a condition, restriction or limitation on their license, certification or registration related to an alcohol, chemical dependency, or health condition or if other evidence indicates that the practitioner has an alcohol, chemical dependency problem or health condition and there is no clear evidence and documentation demonstrating that the practitioner has complied with all such conditions, limitations, or restrictions and is receiving treatment adequate to ensure that the alcohol, chemical dependency problem or health condition will not affect the quality of the practitioner’s practice.
6. Practitioner has 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
7. Practitioner has or has ever had any denials, limitations, suspensions or terminations of participation of privileges by any health care institution, plan, facility or clinic.
8. Practitioner’s history of medical malpractice claims or professional liability claims or settlements reflect what constitutes a pattern of questionable or inadequate treatment or contain what constitutes any gross or flagrant incident or incidents of malpractice.
9. Practitioner has a criminal history, including, but not limited to, any criminal charges, criminal investigations, convictions, no-contest pleas and guilty pleas.
10. Practitioner has 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 practitioner’s professional conduct or the health, safety or welfare of Molina Healthcare Members.
11. Practitioner has or has ever engaged in acts which Molina Healthcare, in its sole discretion, deems inappropriate.
12. Practitioner 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 Healthcare Members.
13. Practitioner has not complied with Molina Healthcare’s quality assurance program.
15. Practitioner is found to have rendered a pattern of substandard care or is responsible for any gross or flagrant incident of substandard care.
16. Practitioner has or has ever displayed inappropriate patterns of referral, which deviate substantially from reasonably expected patterns of referral.
17. Practitioner makes or has ever made any material misstatements in or omissions from their credentialing application and attachments.
18. Practitioner has ever rendered services outside the scope of their license.
19. Practitioner 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.
20. Practitioner has or has ever failed to comply with the Molina Healthcare Medical Record Review Guidelines.
21. Practitioner has or has ever failed to comply with the Molina Healthcare Site Review or Medical Record

Monitoring on a Committee Watch Status (13.18.3)
Molina Healthcare uses the credentialing category “watch status” for practitioners whose initial or continued participation is approved by the Credentialing Committee with follow-up to occur. The Credentialing Committee may approve a practitioner to be monitored on watch status when there are unresolved issues or when the Credentialing Committee determines that the practitioner needs to be monitored for any reason.

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

Corrective Action (13.18.4)
In cases where altering the conditions of participation is based on issues related to quality of care and/or service, Molina Healthcare may work with the practitioner to establish a formal corrective action plan to improve performance, prior to, or in lieu of suspending or terminating his or her participation status.

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

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

Within ten (10) calendar days of the Credentialing Committee’s decision to place practitioner on a corrective action plan, the practitioner 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 practitioner’s performance may or may not be monitored, as deemed appropriate. If the corrective action(s) are not adequately resolved within the designated time, depending on the circumstances of the case, the Credentialing Committee may recommend that the
practitioner continue on an improvement plan, or recommend suspension or termination. All recommendations for termination that result from a lack of appropriate practitioner response to corrective action will be brought to the Credentialing Committee for review and decision.

**Summary Suspension (13.18.5)**

In cases where the Credentialing Committee or the Medical Director becomes aware of circumstances that pose an immediate risk to patients, the practitioner may be summarily suspended from participation in the network, without prior notice, pending review and investigation of information relevant to the case.

Such summary suspension shall become effective immediately upon imposition, and the Medical Director shall promptly notify the practitioner of the suspension 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 practitioner
- The length of the suspension
- The estimated timeline for determining whether or not to reinstate or terminate the practitioner
- Details regarding the practitioners right to request a fair hearing within 30 calendar days 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 practitioner does not request a fair hearing within the 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 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 practitioner’s continued participation, discontinue the suspension or terminate the practitioner.

**Denial (13.18.6)**

After review of appropriate information, the Credentialing Committee may determine that the practitioner should not be approved for participation in the Molina Healthcare network. The Credentialing Committee may then vote to deny the practitioner.

The practitioner will not be reported to the NPDB and will not be given the right to a fair hearing. Within ten (10) calendar days of the Committee’s decision, the practitioner is sent a written notice of denial via certified mail, from the Medical Director, which includes the reason for the denial.

**Termination (13.18.7)**

After review of appropriate information, the Credentialing Committee may determine that the practitioner does not meet performance expectations pertaining to quality of care, services or established performance/professional standards. The Credentialing Committee may then vote to terminate the practitioner.

**Terminations For Reasons Other Than Unprofessional Conduct or Quality of Care (13.18.8)**

If the termination is based on reasons other than unprofessional conduct or quality of care, the
practitioner will not be reported to the NPDB and will not be given the right to a fair hearing. Within ten (10) calendar days of the Committee’s decision, the practitioner is sent a written notice of termination via certified mail, from the Medical Director, which includes the following:

1. A Description of the action being taken
2. Reason for termination

**Terminations Based On Unprofessional Conduct or Quality of Care (13.18.9)**

If the termination is based on unprofessional conduct or quality of care, the practitioner will be given the right to a fair hearing.

Within ten (10) calendar days of the Committee’s decision, the practitioner is sent a written notice of Molina Healthcare’s intent to terminate them from the network, via certified mail from the Medical Director, which includes the following:

- A Description of the action being taken
- Reason for termination
- Details regarding the practitioner’s right to request a fair hearing within 30 calendar days of receipt of notice (see Fair Hearing Plan policy). The Fair Hearing Policy explains that Molina Healthcare will appoint a hearing officer and a panel of individuals to review the appeal.
- The practitioner does not request a fair hearing within the 30 calendar days, they have waived their rights to a hearing.
- The notice will include a copy of the Fair Hearing Plan Policy describing the process in detail.
- Practitioner’s right to be represented by an attorney or another person of their choice.
- Obligations of the practitioner regarding further care of Molina Healthcare patients/Members
- The action will be reported to the NPDB and the State Licensing Board.

Molina Healthcare will wait 30 calendar days from the date the terminated practitioner received the notice of termination. If the practitioner requests a fair hearing within that required timeframe, Molina Healthcare will follow the Fair Hearing Plan Policy. Once the hearing process is completed, the practitioner will receive written notification of the appeal decision which will contain specific reasons for the decision (see Fair Hearing Plan Policy). If the hearing committee’s decision is to uphold the termination, the action will be reported to the State Licensing Board and the NPDB as defined in reporting to appropriate authorities section below. If the hearing committee overturns the termination decision and the practitioner remains in the Molina Healthcare network, the action will not be reportable to the State Licensing Board or to the NPDB.

If the practitioner does not request a hearing within the 30 calendar days, they have waived their rights to a hearing and the termination will become the final decision. A written notification of the final termination will be sent to the practitioner and the termination will be reported to the State Licensing Board and the NPDB as defined in reporting to appropriate authorities section below.

**Reporting to Appropriate Authorities (13.18.10)**

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

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

Within 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 practitioner 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 Practitioner’s credentials file. The action is also reported to other applicable State entities as required.

Section 13.19 Fair Hearing Plan Policy

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

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

Definitions (13.19.1)

- Adverse Action shall mean an action that entitles a provider to a hearing, as set forth in Section B (l)-(3) below.
- Chief Medical Officer shall mean the Chief Medical Officer for the respective Molina Healthcare affiliate state plan wherein the provider is contracted.
- Days shall mean calendar days. In computing any period of time prescribed or allowed by this Policy, the day of the act or event from which the designated period of time begins shall not be included.
- Medical Director shall mean the Medical Director for the respective Molina Healthcare affiliate state plan wherein the provider is contracted.
- Molina Healthcare Plan shall mean the respective Molina Healthcare affiliate state plan wherein the provider is contracted.
- Notice shall mean written notification sent by certified mail, return receipt requested, or personal delivery.
- Peer Review Committee or Credentialing Committee shall mean a Molina Healthcare Plan committee or the designee of such a committee.
- Plan President shall mean the Plan President for the respective Molina Healthcare affiliate state plan wherein the provider is contracted.
- Provider shall mean physicians, dentists, and other health care practitioners as defined by 42 USC 11151 and Social Security Act § 1861(u).
- State shall mean the licensing board in the state in which the provider practices.
- State Licensing Board shall mean the state agency responsible for the licensure of provider.
- 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 Healthcare Plan.
Grounds for a Hearing (13.19.2)
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 Healthcare Provider status when such revocation, termination, or expulsion is reportable to the State Licensing Board, NPDB, and/or HIPDB.
- Suspension, reduction, limitation, or revocation of authority to provide care to Molina Healthcare Members when such suspension, reduction, limitation, or revocation is reportable to the State Licensing Board, NPDB, and/or HIPDB.
- Any other final action by Molina Healthcare that by its nature is reportable to the State Licensing Board, NPDB, and/or HIPDB.

Notice of Action (13.19.3)
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 Healthcare 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.
- Provide a summary of the provider's hearing rights or attach a copy of this Policy.

Request for a Hearing – Waiver (13.19.4)
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.

A provider who fails to request a hearing within the time and in the manner specified above waives his or her right to any hearing to which he or she might otherwise have been entitled. If the provider waives his or her right to any hearing by failing to request a hearing within the time and in the manner specified above, the recommendation of the Peer Review Committee and/or Credentialing Committee taking or recommending the Adverse Action shall be forwarded to the Chief Medical Officer for final approval. In the event of a submittal to the Chief Medical Officer upon the provider’s waiver as set forth herein, the Peer Review Committee and/or Credentialing Committee may submit to the Chief Medical Officer additional information relevant to its recommended Adverse Action to be considered by the Chief Medical Officer in accepting or rejecting the recommended Adverse Action.
Appointment of a Hearing Committee (13.19.5)

- 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.

- 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.

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.

- 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.

- 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 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.

Hearing Officer (13.19.6)

Selection

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

- Scope of Authority
  - The Hearing Officer shall have the sole discretion and authority to:
    - Exclude any witness, other than a party or other essential person.
    - Determine the attendance of any person other than the parties and their counsel and representatives.
    - For good cause shown to postpone any hearing upon the request of a party or upon a Hearing Committee’s own initiative, and shall also grant such postponement when all of the parties agree thereto.
Responsibilities

The Hearing Officer shall:

- Guide the hearing process, including endeavoring to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner;
- Ensure that proper decorum is maintained;
- Be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing;
- Issue rulings pertaining to matters of law, procedure and the admissibility of evidence;
- Issue rulings on any objections or evidentiary matters;
- Discretion to limit the amount of time;
- Assure that each witness is sworn in by the court reporter;
- May ask questions of the witnesses (but must remain neutral/impartial);
- May meet in private with the panel Members to discuss the conduct of the hearing;
- Remind all witnesses at the conclusion of their testimony of the confidentiality of the hearing;
- Participate in the deliberations of the Hearing Committee as a legal advisor, but shall not be entitled to vote; and
- Prepare the written report.

Time and Place of Hearing (13.19.7)

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.

Notice of Hearing (13.19.8)

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

- The date, time and location of the hearing.
- The name of the Hearing Officer.
- The names of the Hearing Committee Members.
- A concise statement of the affected provider’s alleged acts or omissions giving rise to the Adverse Action or recommendation, and any other reasons or subject matter forming the basis for the Adverse Action or recommendation which is the subject of the hearing.
- The names of witnesses, so far as they are then reasonably known or anticipated, who are expected to testify on behalf of the Peer Review Committee and/or Credentialing Committee, provided the list may be updated as necessary and appropriate, but not later than ten (10) days prior to the commencement of the hearing.
- A list of all documentary evidence forming the bases of the charges reasonably necessary to enable the provider to prepare a defense, including all documentary evidence which was considered by the Peer Review Committee and/or Credentialing Committee in recommending the Adverse Action.
- Except with regard to the disclosure of witnesses, as set forth above, the Notice of Hearing may be
amended from time to time, but not later than the close of the case at the conclusion of the hearing by the Hearing Committee. Such amendments may delete, modify, clarify or add to the acts, omissions, or reasons specified in the original Notice of Hearing.

Pre-Hearing Procedures (13.19.9)

- 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 Healthcare’s expense, any documents or other evidence relevant to the charges which the provider has in his or her possession or control as soon as practicable after receiving the hearing request.

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;
- 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.

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

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.

Conduct of Hearing (13.19.10)

- 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.

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.

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.

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.

Rules for Hearing:

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

- 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.

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

Close of the Hearing (13.19.11)
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.

Burden of Proof (13.19.12)
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.

Provider Failure to Appear or Proceed (13.19.13)
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.
**Record of the Hearing/Oath (13.19.14)**
A court reporter shall be present to make a record of the hearing proceedings and the pre-hearing proceedings, if deemed appropriate by the Hearing Officer. The cost of attendance of the reporter shall be borne by Molina Healthcare, but the cost of the transcript, if any, shall be borne by the party requesting it. The Hearing Officer shall be required to order that all oral evidence be taken by oath administered by a person lawfully authorized to administer such oath.

**Representation (13.19.15)**
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.

**Postponement (13.19.16)**
The Hearing Officer, for good cause shown, may postpone any hearing upon the request of a party or the Hearing Committee.

**Notification of Finding (13.19.17)**
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.

**Final Decision (13.19.18)**
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.

**Reporting (13.19.19)**
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 Healthcare will submit a report to the State Licensing Board, NPDB, and/or HIPDB, as required. Reports shall be made in accordance with the Credentialing Program Policy. Reports to the State Licensing Board, NPDB, and/or HIPDB for adverse actions must be submitted within 15 days from the date the adverse action was taken.

**Exhaustion of Internal Remedies (13.19.20)**
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.

**Confidentiality and Immunity (13.19.21)**
Information regarding any practitioner 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 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 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 practitioner’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 practitioner’s or provider’s provision of patient care services.

By providing patient care services at Molina Healthcare, a practitioner or provider:

1. Authorizes representatives of Molina Healthcare to solicit, provide, and act upon information bearing on the practitioner’s or provider’s qualifications.
2. 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.
3. Acknowledges that the provisions of this policy and procedure are express conditions of the application for, or acceptance of, Molina Healthcare 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:

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

Immunity from Liability for Action Taken: No representative shall be liable to a practitioner or 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 practitioner or 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 practitioner or 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 14
PROVIDER INQUIRIES and MEMBER APPEALS & GRIEVANCES

Providers may inquire on a claim denial on their behalf in accordance with Molina Healthcare policy. Molina Healthcare 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.

Section 14.1 Definitions

Member Appeal: An Appeal is a request for Molina Healthcare to review a decision made resulting from a notice of action. Appeals may be made by Members or their authorized representative such as a family Member or providers.

Claim Inquiry: A request to review a claim related decision that the provider may not agree with.

Claim Reconsideration Request Form (CRRF): A standardized form completed by providers requesting a review of a claim.

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

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

Expeditied Appeal: An Expedited Appeal is a request for Molina Healthcare to review a decision in response to clinical urgency of a situation that could result in one of the following circumstances if a non-urgent determination was made:

I. Services for a Member with an ongoing course of treatment where the denial of such services could seriously jeopardize the life or health of a Member or the Member’s ability to attain, maintain, or regain maximum function or;

II. or the Member would be subject to severe pain that cannot be adequately managed without the care or treatment that is subject of the request.

Grievance: Grievance means an expression of dissatisfaction by a Member or a Member’s authorized representative, including complaints and requests for disenrollment, about any matter other than a matter that is subject to an appeal.

Grievance Committee: The Member Grievance Committee is an interdisciplinary team established by Molina Healthcare to hear Member grievances that are not appropriate for informal review, were denied at the informal review process or not appropriate for the procedures set up under the Managed Care Reform and Patient Rights Act. The committee also reviews data and identifies opportunities for improvement in relation to the grievance process.

Section 14.2 Provider Inquiry Process

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

Molina Healthcare 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 Healthcare or regulatory agency reviews as required. The provider shall not charge the Member or Molina Healthcare for medical record copies when submitted for this review purpose.

Section 14.3 Provider Complaints

Providers have the right to file a complaint if they are dissatisfied with any aspect of operation or service rendered by Molina Healthcare 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 Healthcare at the following address:

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

Section 14.4 Member Appeals Processes

Molina Healthcare Members or the personal representatives of Members have the right to file a grievance and submit an appeal through a formal process. All grievances and appeals must first be submitted to Molina Healthcare for resolution, but may later be appealed to the Illinois Department of Healthcare and Family Services (HFS). However, the filing of a grievance does not preclude the Member from filing a complaint with HFS.
This section addresses the identification, review and resolution of Member grievances and appeals. Below are Molina Healthcare’s Member Grievance and Appeals Process.

Appeals may be submitted by Members or an authorized representative, such as a family Member or their provider in response to a Notice of Action. If Molina Healthcare’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 Healthcare customer service phone number where more information regarding the appeal process can be obtained
- The availability of the Illinois State Department of Insurance

**Type of Appeals (14.4.1)**

A Member may request an expedited appeal, standard pre-service appeal, or post service appeal (retrospective appeal).

Standard pre-service appeals are requested to change an adverse determination for care or services that the plan reviews, in whole or in part, in advance of the Member obtaining the care or services. Pre-service appeals are the only appeal type eligible for expedited appeal processing.

Post-service or retrospective appeals are generally a request to change an adverse determination for payment for care or services that the Member has already received. These are the only appeals that may be requested by the provider on their behalf. A post service/retrospective review will never result in approval as an expedited review.

**Member Authorized Representative (14.4.2)**

A Member 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 Healthcare with the appeal request. Molina Healthcare 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. Written consent received after the 15-day timeframe will be reviewed if it is within the 60-day appeal timeframe.

Molina Healthcare 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.

**Standard Appeals Process and Timeline (14.4.3)**

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 Healthcare’s Customer Service department. Standard appeal requests submitted in writing should be sent to the address or fax number below:
A written request for an appeal must include the Member’s name, address, Member 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 Healthcare to accept the late request such as, the Member being seriously ill preventing the ability to file the appeal.

Upon receipt of an appeal, Molina Healthcare will notify the party filing the appeal, within three business days, 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 Healthcare will render a decision on the appeal within 15 business days after receipt of the required information. Molina Healthcare 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 Healthcare Healthcare’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.

Members who are not satisfied with Molina Healthcare’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 Family Health Plan population, Integrated Care Program (ICP) Service Package I, or if they are part of the Supportive Living Facility (SLF) or Aging waiver populations within ICP Service Package II:

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

HFS may also be contacted electronically at http://www.hfs.illinois.gov.
Members who are not satisfied with Molina Healthcare’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 ICP Service Package II:

Illinois Department of Human Services
Bureau of Fair Hearings
69 W. Washington, 4th Fl.
Chicago, IL 60602
Fax: (312) 793-2005
Call: (855) 418 4421
For hearing impaired, TTY at (800) 526-5812

Expedited Internal Appeals Process and Timeline (14.4.4)
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 Member do not require signed written consent of the Member. A request to expedite an appeal will be considered in situations where applying the standard procedure could seriously jeopardize the Member’s life, health or ability to regain maximum function. An expedited review is not possible when services have already been provided to the Member.

Upon receipt of appeal, Molina Healthcare 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 Healthcare will render a decision within 24 hours of receiving the required information. If additional information required to make the final appeal determination is not received within 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 Healthcare automatically processing the appeal as a standard appeal. The 15-business day timeframe from the date the request was received will be initiated.

Molina Healthcare will notify the party filing the appeal, the Member (or designated representative) the Member’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 calendar days or the oral notification.

External Independent Review (14.4.5)
An external independent review may be requested by a non-waiver Member (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 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 Healthcare will do the following within 30 days of receipt of request for External Independent Review:

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

Molina Healthcare will review all requests within five days after receiving all of the necessary information, the 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 Healthcare will pay for the service. Molina Healthcare will notify the requestor orally and in writing of the results of the external independent review.

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

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

**Expedited External Independent Review (14.4.6)**
A request for an expedited independent review may be made orally or in writing. Molina Healthcare will review the information and notify the requestor within 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 Member’s life or health. Molina Healthcare will ensure all external independent reviews are determined as expeditiously as possible, as and no later than 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 72 hours, a determination will be made with the current information available. Molina Healthcare will notify the requestor orally of the results of the expedited external independent review within 24 hours after receipt of the required information. Written notification will be sent within two calendar days from the date the decision was made.

**Illinois Department of Healthcare and Family Services (HFS) Review (14.4.7)**
Members not satisfied with the determination of the independent reviewer may request a State Hearing with HFS for non-waiver services. Parties to the review include Molina Healthcare and the Member (or authorized representative).

Requests for HFS review must be filed within 30 days of 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
Call: (855) 418-4421
For hearing impaired, TTY at (800) 526-5812

HFS may also be contacted electronically at [http://www.hfs.illinois.gov](http://www.hfs.illinois.gov).

**Second opinion (14.4.8)**
If a Member does not agree with their provider’s plan of care, they have the right to a second opinion from another provider. A Member can call Member Services to find out how to get a second opinion at no cost to the Member. Family Health Plan Members can call (855) 687-7861. Integrated Care Plan Members can call (855) 766-5462; TTY: 711, Monday-Friday, 8:00 a.m. - 5:00 p.m.
Section 14.5 Member Grievance Process

Molina Healthcare has an organized grievance process to ensure thorough, appropriate and timely resolution to Members' grievances. 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 Healthcare 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
Via fax: (866) 771-0117

Members are notified of their grievance and appeal rights and the different levels of grievances and appeals through various general communications including, but not limited to, the Member Handbook, Evidence of Coverage and Disclosure, Member newsletters and Molina Healthcare’s website.

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

The Member (or designated representative) shall have the right to attend and participate in the formal grievance proceedings as established through the Molina Healthcare Grievance Committee process.

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

Members will continue any and all benefits while in the appeals process unless previously dis-enrolled from Molina Healthcare.

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.

Grievance Timeline (14.5.1)
A Member may file a grievance within 90 days of the incident or following the date the Member was made aware of the incident.

A written and signed acknowledgement of the grievance is sent to the Member within three business days of receipt. A determination will be made by the Grievance Committee expeditiously.

Molina Healthcare will provide the Member (or designated representative) notification of outcome. Where grievance was final appeal step, Molina Healthcare will also provide notification of the availability of the Illinois State Department of Insurance to respond to Member inquires.
Section 14.6 Reporting

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

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

Section 14.7 Record Retention

Molina Healthcare will maintain all grievance and related appeal documentation on file for a minimum of six years. In addition to the information documented electronically via the Appeals and Grievances log or maintained in other electronic files, Molina Healthcare will retain copies of any written documentation submitted by the provider pertaining to the grievance/appeal process. Provider shall maintain records for a period not less than 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 Healthcare’s prior approval for the disposition of records if agreement is continuous.
Section 15
MEDICAL GROUP/IPA OPERATIONS

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

Section 15.1 Delegation of Administrative Functions

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

- Claims payment
- Credentialing
- Utilization Management (UM)

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

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

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

<table>
<thead>
<tr>
<th>Medical Group/IPA Full Name</th>
<th>ID card Acronym</th>
<th>Claims Remit to Address</th>
<th>UM Referral/Authorization Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

Section 15.2 Delegation Criteria

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

Section 15.3 Credentialing

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

- Be accredited by the National Committee for Quality Assurance (NCQA) for credentialing or pass Molina Healthcare’s credentialing pre-assessment, which is based on NCQA credentialing
standards, with a score of at least 80%

- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina Healthcare
- Agree to Molina Healthcare’s contract terms and conditions for credentialing delegates
- Submit timely and complete credentialing reports to Molina Healthcare
- Comply with all applicable federal and state laws
- When key specialists, as defined by Molina Healthcare, contracted with IPA or group terminate, they shall provide Molina Healthcare with a letter of termination according to contractual agreements and the information necessary to notify affected Members

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

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

**Section 15.4 Utilization Management**

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

- Have a UM program that has been operational at least one year prior to delegation
- Be NCQA accredited for utilization management or pass Molina Healthcare’s UM pre-assessment, which is based on NCQA credentialing standards, with a score of at least 80%
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina Healthcare
- Agree to Molina Healthcare’s contract terms and conditions for UM delegates
- Submit timely and complete UM delegate reports to Molina Healthcare
- Comply with the standard Transactions and Code Sets requirements for authorization requests and responses using the formats required by HIPAA
- Comply with all applicable federal and state laws

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

**Section 15.5 Claims**

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

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

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

Section 15.6 Quality Improvement/Preventive Health Activities

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

Section 15.7 Delegation Reporting Requirements

Medical groups/IPAs, contracted with Molina Healthcare and delegated for various administrative functions, must submit monthly reports to Molina Healthcare’s FTP site within the timeline indicated by the health plan. For a copy of Molina Healthcare’s current delegation reporting requirements, please contact Molina Healthcare Provider Services at Illinoisprovider@MolinaHealthcare.com or (888) 858-2156.
Section 16
CULTURAL COMPETENCY

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

Training of employees and providers, and quality monitoring are the cornerstones of successful culturally competent service delivery. For that reason, the cultural competency program is integrated into the overall provider training and quality monitoring programs. An integrated quality approach is aimed at enhancing the way people think about our Members, service delivery and program development so that cultural competency becomes a part of everyday thinking.

Section 16.1 Provider and Community Training

Molina Healthcare offers educational opportunities in cultural competency concepts for providers on a regular basis. This is a summary of the Cultural Competency Plan; providers may use links on the Molina Healthcare website to obtain the full Cultural Competency Plan.

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

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

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

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

Section 16.2 Integrated Quality Improvement

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

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

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

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

**Section 16.3 Program and Policy Review Guidelines**

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

- Annual review of membership demographics (preferred language, ethnicity, race)
- Local geographic population demographics and trends derived from publicly available sources (Group Needs Assessment) Network Assessment
- Applicable national demographics and trends derived from publicly available sources
- Health status measures such as those measured by HEDIS® as available comparison with selected measures such as those in Healthy People 2010 Measures available through national testing programs such as the National Health and Nutrition Examination Survey (NHANES)
Section 17
THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) REQUIREMENTS AND INFORMATION

Section 17.1 Molina Healthcare’s Commitment to Patient Privacy

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

Provider/Practitioner Responsibilities (17.1.1)
Molina Healthcare expects that its contracted providers/practitioners will respect the privacy of Molina Healthcare Members and comply with all applicable laws and regulations regarding the privacy of patient and Member PHI.

Applicable Laws (17.1.2)
Providers/practitioners must understand all state and federal healthcare privacy laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that protects all health information in the United States; instead there is a patchwork of laws that providers/practitioners must comply with. In general, most healthcare providers/practitioners are subject to various laws and regulations pertaining to privacy of health information including, without limitation, the following:

1. Federal Laws and Regulations
   - HIPAA
   - Medicare and Medicaid laws
2. Applicable State [Illinois] Laws and Regulations

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

Section 17.2 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 entity2. 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 “services3

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

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

3 See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule.
relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:

- Quality improvement
- Disease management
- Case management and care coordination
- Training Programs
- Accreditation, licensing, and credentialing

Importantly, this allows providers/practitioners to share PHI with Molina Healthcare for our healthcare operations activities, such as HEDIS® and QI.

Written Authorizations (17.2.1)
Uses and disclosures of PHI that are not permitted or required under applicable law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable state law. A sample Authorization for the Use and Disclosure of PHI is included at the end of this section.

Section 17.3 Patient Rights

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

Notice of Privacy Practices (17.3.1)
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.

Requests for Restrictions on Uses and Disclosures of PHI (17.3.2)
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.

Requests for Confidential Communications (17.3.3)
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.

Requests for Patient Access to PHI (17.3.4)
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.

Request to Amend PHI (17.3.5)
Patients have a right to request that the provider/practitioner amend information in their designated record set.

Request Accounting of PHI Disclosures (17.3.6)
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.
Section 17.4 HIPAA Security

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

In addition, medical identity theft is an emerging threat in the healthcare industry. Medical identity theft occurs when someone uses a person’s name and sometimes other parts of their identity—such as health insurance information—without the person’s knowledge or consent to obtain healthcare services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to Molina Healthcare.

HIPAA Transactions and Code Sets (17.4.1)

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

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

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

National Provider Identifier (17.4.2)

Provider/practitioners must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The provider/practitioners must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the provider/practitioner. The provider/practitioner must report its NPI and any subparts to Molina Healthcare and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within thirty (30) days and should also be reported to Molina Healthcare within thirty (30) days of the change. Provider/practitioners must use its NPI to identify it on all electronic transactions required under HIPAA and on all claims and encounters (both electronic and paper formats) submitted to Molina Healthcare.

Additional Requirements for Delegated Providers/Practitioners (17.4.3)

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

Section 17.5 Molina Healthcare Authorization For Use and Disclosure of PHI Form
AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Member Name:______________________________ Member ID #:________________
Member Address:____________________________ Date of Birth:______________
City/State/Zip:______________________________ Telephone #:________________

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

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

__________________________________________________________________________
__________________________________________________________________________

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

__________________________________________________________________________
__________________________________________________________________________

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

__________________________________________________________________________
__________________________________________________________________________

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

__________________________________________________________________________
__________________________________________________________________________

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

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

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

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

10. I understand that I may revoke this authorization at any time by notifying Molina Healthcare in writing, except to the extent that:

   a. action has been taken in reliance on this authorization; or
   b. if this authorization is obtained as a condition of obtaining health care coverage, other law provides the health plan with the right to contest a claim under the benefits or coverage under the plan.

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

12. This authorization expires on the following date or event*:

   ____________________________________________________________

*If no expiration date or event is specified above, this authorization will expire 12 months from the date signed below.

<table>
<thead>
<tr>
<th>Signature of Member or Member’s Personal Representative</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Printed Name of Member or Member’s Personal Representative, if applicable</th>
<th>Relationship to Member or Personal Representative’s Authority to act for the Member, if applicable</th>
</tr>
</thead>
</table>

A copy of this signed form will be provided to the Member, if the authorization was sought by Molina Healthcare
Section 18
GLOSSARY OF TERMS

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

**Acute Inpatient Care** – Care provided to persons sufficiently ill or disabled requiring:
- Constant availability of medical supervision by attending provider or other medical staff
- Constant availability of licensed nursing personnel
- Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to ensure proper medical management by the provider

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

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

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

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

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

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

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

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

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

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

**Complaint** – Any written or oral expression of dissatisfaction.
Covered Services – Medically necessary services included in the state contract. Covered services change periodically as mandated by federal or state legislation.

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


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

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

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

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

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

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

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

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

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

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

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

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

- Receives a grant under Section 329, 330 or 340 of the Public Health Service Act; or
- Based on the recommendation of the Health Resources and Services Administration within the Public Health Service, are determined to meet the requirements for receiving such a grant.

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

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

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

HFS- Illinois Department of Health and Family Services

HIPAA – Health Insurance Portability and Accountability Act

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

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

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

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

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

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

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

Medicare – The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the SSA. Medicare has two parts:
Part A covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.

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

**Member** – A current or previous member of Molina Healthcare.

**NCQA** – National Committee for Quality Assurance

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

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

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

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

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

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

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

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

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

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

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

**State Children’s Health Insurance Plan (SCHIP)** – A federal/state funded health insurance program authorized by Title XXI of the SSA and administered by HFS.
Supplemental Security Income (SSI) – A federal cash program for aged, blind, or disabled persons, administered by the SSA.

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

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

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

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

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

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

Utilization Management (UM) – The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as providing assistance to a clinician or patient in cooperation with other parties, to ensure appropriate use of resources. UM includes prior Authorization, concurrent review, retrospective review, discharge planning and case management.
Section 19
MOLINA HEALTHCARE OF ILLINOIS FORMS

Section 19.1 Prior Authorization Guide and Forms


In addition to the PA Guide, the following prior authorization forms are available:

- Prior Authorization Guide and Form
- Behavioral Health Outpatient Treatment Request Form
- Behavioral Health Higher Level of Care Request Form
- Pharmacy Prior Authorization Form

Section 19.2 Administrative Guides and Forms

Molina Healthcare of Illinois has posted copies of the following administrative forms and reference guides online at http://www.molinahealthcare.com/providers/il/medicaid/forms/Pages/fuf.aspx:

- Non-Par Provider Contract Request Form
- CAQH Form
- MCO Hospital Access Program Participation Agreement
- HFS Illinois Medicaid Program Provider Application
- Open Panel Form
- Provider Information Update Form
- Corrected Claims Form
- Claims Reconsideration Form
- Quick Reference Contact Sheet
- Guide To Provider Changes
- Long Term Supports & Services Billing Guidelines
- Critical Incident Reference Guide