2016
Provider Manual

Centennial Care

Revisions

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Thank you for being a partner with Molina Healthcare of New Mexico!

Dear Practitioner/Provider:

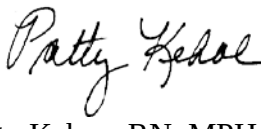
This manual was designed to provide you with assistance in all areas of your practice, from making referrals to receiving payment for your services. In some cases, you may have developed internal procedures that meet the standards set out in this manual. In these instances, you do not need to change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

From time to time, this manual may be revised as policies, program or regulatory requirements change. All changes and updates will be updated and posted to the Molina Healthcare of New Mexico (Molina Healthcare) website as they occur.

Contracted practitioners/providers are an essential part of delivering quality care to our Members. We value our partnership and appreciate the family-like relationship that you pass on to our Members. As our partner, assisting you is one of our highest priorities. We welcome your feedback and support your efforts to provide quality care.

Thank you for your active participation in the delivery of quality healthcare services to Molina Healthcare Members.

Sincerely,



Patty Kehoe, RN, MPH, CCM
President
Molina Healthcare of New Mexico, Inc.

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Section 1 – Background and Overview of Molina Healthcare, Inc.

A. Introduction to Centennial Care

This manual serves as a guide for providing covered services to Molina Healthcare Members enrolled in Centennial Care, which is the name for New Mexico's new Medicaid Managed Care Program. The cornerstone of this program is a single, comprehensive delivery system for medical, behavioral, and long-term care services, which emphasizes care coordination so that recipients will receive the right care, in the right place, at the right time, leading to better health outcomes. Central to this approach are:

- Assessing each Member's physical, behavioral, functional, and psychosocial needs;
- Identifying the medical, behavioral, and long-term care services and other social support services and assistance;
- Ensuring timely access and provision, coordination, and monitoring of services needed to help each Member maintain or improve his or her physical and/or behavioral health status; and
- Facilitating access to other social support services and assistance needed in order to promote each Member's health, safety, and welfare.

Molina Healthcare updates and publishes the Provider Manual once a year. All contracted practitioners /providers **(collectively referred to going forward in this Manual as "Provider" or "Providers")** will be notified of any additional updates or changes that occur either via the Provider Newsletter or by letter. To receive a printed version of the manual, please contact your Provider Services Representative at (505) 342-4660 or toll free at (800) 377-9594.

This manual is supplemented by additional Provider Reference Manuals:

Molina Medicare - Molina Medicare Provider Manual
Molina Healthcare Marketplace - Molina Healthcare Marketplace Provider Manual

B. Company Profile

Molina Healthcare, Inc. (MHI) is a family-founded, physician-led managed care organization headquartered in Long Beach, California. Founded more than thirty years ago, MHI has grown to serve approximately 3.5 million Members across the nation.

MHI and affiliated health plans focus on providing healthcare services to people who receive benefits through government-sponsored programs such as Medicaid and Medicare. MHI strives to break down the financial, cultural and linguistic barriers that prevent low-income families and individuals from accessing appropriate healthcare – and does so by collaborating with state government programs. MHI is an exceptional health care organization focused on improving access to quality care, increasing coordination of care and improving health outcomes for Medicaid Members; all while cultivating a culturally sensitive and provider-friendly environment.

C. David Molina, M.D., founded the company in 1980 as a provider organization with a network of primary care clinics in California. As the need for effective management and delivery of healthcare services to underserved populations continued to grow, MHI became licensed as a Health Maintenance Organization (HMO) in California. Dr. Molina believed that each person should be treated like family, and that each person deserves quality care. The company remains devoted to that mission.

MHI is committed to quality and has made accreditation a strategic goal for each of its health plans. Year after year, Molina health plans have received accreditation from the National Committee for Quality Assurance (NCQA). The NCQA accreditation process sets the industry standard for quality in health plan operations. For six consecutive years, Molina Healthcare has earned an "Excellent" ranking from NCQA.

In addition to operating health plans and primary care clinics, Molina Medicaid Solutions provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems to support the administration of state Medicaid and other health care entitlement programs. Molina Medicaid Solutions is currently contracted with the states of Idaho, Louisiana, Maine, New Jersey and West Virginia.

C. Network Management and Operations Department

The Network Management and Operations Department (NMO) is devoted exclusively to the needs of contracted providers.

- **Provider Contracting.** The staff in this area builds the contracted network through negotiated agreements within New Mexico, bordering states and across the nation. They work with providers to help them understand both terms and fee schedules and they amend contracts as needed from time-to-time due to regulatory or program requirements.
- **Provider Inquiry, Research and Resolution (Appeals).** This area addresses Provider appeals, grievances and reconsideration processes regarding claims payments and/or denials.
- **Member Advocacy - Grievances, Appeals and Fair Hearings.** This area helps Members with their concerns and disagreements with coverage decisions.
- **Provider Services.** This area has dedicated Provider Service Representatives (PSRs) to provide training and conduct visits to provider offices, answer questions and serve as the point of contact for all provider needs. The PSR Territory Map reflects the service area, the PSR responsible for each of these geographic areas and their contact information and may be found in the Contact Information for Providers Section below.

Section 2 – Contact Information for Providers

A. Correspondence / Mailing Address

For claim reconsiderations, complaints and appeals; notification of address, telephone, contract status, tax identification, name, affiliation, open/closed panel, etc.:

Molina Healthcare of New Mexico, Inc.
P.O. Box 3887
Albuquerque, NM 87190 – 9859

Provider Services and other areas within Network Management and Operations including Provider Contracting, Provider Information and Data Management, Appeals and Training and Communication		
The Provider Services Representative (PSR) Contact Sheet and Territory Map – by specialty and area of the state – is located on the Molina Healthcare Provider website at: **PSR Contact Grid**	Albuquerque Toll Free Fax	(505) 342-4660 (800) 377-9594 (505) 798-7313
24 Hour Nurse Advice Line / After Hours Behavioral Health Crisis Line		
Services available in English and Spanish	English Phone Spanish Phone Hearing Impaired (TTY/TDD)	Toll Free (888) 275-8750 Toll Free (866) 648-3537 Toll Free (866) 735-2929 or dial 711
Appeals and Grievances (24 hours a day / 7 days a week)		
Services available in English and Spanish	Albuquerque Toll Free Phone English Telephone Spanish Telephone for the Hearing Impaired (TTY/TDD)	(505) 342-4663 (800) 723-7762 Toll Free (888) 275-8750 Toll Free (866) 648-3537 Toll Free (800) 659-8331 or dial 711
Care Coordination (Monday through Friday – 8:00 a.m. to 5:00 p.m.)		
	Toll Free Phone Lines Toll Free Fax	(855) 315-5677 (866) 472-4575 for complex, chronic conditions

Claims, Claims Appeals and Eligibility /Verification		
Provider Customer Services **Paper Claims:** Molina Healthcare of New Mexico, Inc. P.O. Box 22801 Long Beach, CA 90801 **To overnight claims:** Molina Healthcare of New Mexico, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802-4317	Albuquerque Toll Free Phone Fax Spanish Hearing Impaired (TTY/TDD)	(505) 341-7493 (888) 825-9266 (505) 342-0595 (866) 648-3537 (800) 659-8331 or dial 711

Complex Medical Care Management / Care Coordination Review		
	Toll Free Phone Toll Free Fax	(800) 377-9594, ext. 181120 (866) 472-4575
Compliance / Anti-Fraud Hotline (24 hours a day/7 days a week)		
Confidential Compliance Official 400 Tijeras Ave NW, Suite 200 Albuquerque, NM 87102	Toll Free Phone Web link	Molina Healthcare AlertLine at: (866) 606-3889 Molina Healthcare Fraud Alert
Credentialing		
Molina Healthcare of New Mexico, Inc. Credentialing Department 400 Tijeras Ave NW, Suite 200 Albuquerque, NM 87102	Albuquerque Toll Free Phone Fax	(505) 342-4660 (800) 377-9594 (505) 348-0932
Dental Services		
Dental Services / Molina Healthcare Member Services – Eligibility and Provider Services Note: Effective May 1, 2016, DentaQuest is no longer the dental administrator. Molina Healthcare is working in partnership with Scion Dental, Inc.	Albuquerque Toll Free Phone Scion Dental Toll Free Phone for provider inquiries regarding joining the dental network	(505) 341-7493 (888) 825-9266 (800) 508-6965

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)		
	Albuquerque Toll Free Phone	(505) 342-4660, ext.182618 (800) 377- 9594, ext.182618
Health Improvement Program		
	Albuquerque Toll Free Phone	(505) 342-4660, ext. 182618 (800) 377- 9594, ext. 182618
Member Services / Provider Customer Services (for eligibility) - 8:00 a.m. to 5:00 p.m.		
	Albuquerque Toll Free Phone Fax Spanish Nurse Spanish TY/TDD Hearing Impaired (TTY/TDD)	(505) 341-7493 (888) 825-9266 (505) 342-0595 (866) 648-3537 (866) 833-4703 (800) 659-8331 or dial 711
Utilization Management, Referrals, and Authorization		
Molina Healthcare of New Mexico, Inc. Utilization Management 400 Tijeras Ave NW, Suite 200 Albuquerque, NM 87102		
Behavioral Health Prior Authorizations - 8:00 a.m. to 5:00 p.m.		
	Toll Free Phone Local Fax Toll Free Fax Secure Email	(855) 315-5677 (505) 924-8237 (888) 295-5494 bhrequests@molinahealthcare.com
Physical Health Prior Authorization		
	Toll Free Phone Medicaid Fax Direct fax Toll Free Fax	(877) 262-0187 (888) 802-5711 (505) 924-8258 (855) 278-0310
NICU, Radiology and Transplant Authorizations		
	Toll Free Phone Toll Free Fax	(855) 714-2415 (877) 731-7218

Pharmacy Prior Authorizations – 8:00 a.m. – 5:00 p.m. (Pharmacy Benefit, Medical Office Drugs, I.V infusion, TPN)		
	Toll Free Phone Toll Free Fax Medicare Part D Phone Medicare Part D Fax	(888) 825-9266 x 186336 (866) 472-4578 (888) 665-1328 (866) 290-1309
Quality Improvement		
Molina Healthcare of New Mexico, Inc. Quality Improvement Department 400 Tijeras Ave NW, Suite 200 Albuquerque, NM 87102	Toll Free Phone Toll Free Fax	(800) 377-9594 (877) 553-6508
Transportation Services		
Integrated Transport Management (ITM)	Toll Free Phone	(888) 593-2052
Vision Services		
March Vision Services	Toll Free Phone	(888) 493-4070

B. Web Portal Services

Molina Healthcare of New Mexico, Inc. (Molina Healthcare) offers a Web Portal to all contracted Medicaid and Medicare providers. Molina Healthcare's Web Portal is a Health Insurance Portability and Accountability Act (HIPAA) secure site that offers real-time information twenty-four (24) hours a day, seven (7) days a week.

In the Web Portal, you will be able to do the following:

- Check Member eligibility and benefits;
- Obtain Primary Care Practitioner (PCP) Rosters;
- Search and manage your service request/authorizations;
- Search and manage claims and status, submit CMS-1500 forms;
- Access forms (credentialing, claim reconsideration requests, prior authorization request /matrix, etc.); and
- Request office/facility demographic update/changes.

Register today to access our on-line services. A video will guide you through the easy on-line registration process. Link into our Web Portal at: Web Portal - Provider Self Serve
Upon registration, practitioners/providers and their staff will be able to perform the

following tasks on-line through Web Portal:

C. Molina Healthcare Website

Molina Healthcare's website provides information, materials, news, updates and much more. Log on to our website at www.molinahealthcare.com to access the following information:

- Provider Manual;
- Provider forms;
- Provider Policies;
- HIPAA Resource Center;
- EDI, EFT/ERA information;
- Drug list;
- Health Resources;
- Provider Newsletters;
- Provider Communications;
- Contact information;
- Clinical Practice Guidelines;
- HEDIS and CAHPS Scores;
- Provider Coding Tools;
- Disease Management/Health Management Programs;
- Preventive Health Guidelines; and
- Critical Incident Reporting.

D. HealthXnet Service

Molina Healthcare is contracted with Hospital Services Corporation (HSC) to provide on-line services for providers through HealthXnet. Upon registration, you and your office staff will be able to perform the following tasks on-line through HealthXnet: Member eligibility, claims status and Service Request (prior authorization status).

To register, contact HealthXnet (low monthly subscription fees will apply): HealthXnet Support Desk
Albuquerque: (505) 346-0290
Toll free: (866) 676-0290 healthxnet@nmhsc.com www.healthxnet.com

E. Health Information Collaborative/ Health Information Exchange

Molina Health Care of New Mexico, Inc. is pleased to participate with the New Mexico Health Information Collaborative (NMHIC), a secure electronic health care information system that allows participating providers to access patient health care information in real time. The Health Information Exchange (HIE) network is designated through the state to connect unrelated heath care systems and providers to be able to access patient records electronically, securely and privately with the patient's consent. Providers can access the most up-to-date lab results, medical history and test information to be more prepared when working closely with the patient in making health care decisions.

HIE increases patient safety by having timely access to medication lists, emergency department

visits, radiology and laboratory results, as well as facility admission and discharge details to have a more concise and comprehensive patient medical record. Patient health information is shared following federal guidelines in accordance with the Health Insurance Portability and Accountability Act (HIPAA). For more information, visit the New Mexico Health Information Collaborative website at www.nmhic.org.

Section 3 – Member Eligibility, Enrollment and Health Assessment

A. Member Eligibility

HSD determines eligibility for enrollment in the Centennial Care Program. All individuals determined to be Medicaid eligible are required to participate in the Centennial Care Program unless he or she is: (1) a Native American and elects enrollment in the Medical Assistance Division's fee-for-service (FFS) program; or (2) is in an excluded population.

A Native American who does not meet a nursing facility level of care or intermediate care facility for individuals with intellectual disabilities (ICF/IID) levels of care or is not dually-eligible for both Medicaid and Medicare will not be enrolled in the Centennial Care Program unless the eligible recipient elects to enroll.

The following eligible recipients are excluded from Centennial Care Program enrollment:

1. Qualified Medicare beneficiaries (QMB)-only recipients;
2. Specified low-income Medicare beneficiaries;
3. Qualified individuals;
4. Qualified disabled working individuals;
5. Refugees;
6. Participants in the program for all inclusive care for the elderly (PACE); and
7. Children and adolescents in out-of-state foster or adoption placements.

B. Member Enrollment

The New Mexico Human Services Department (HSD) will enroll individuals determined eligible for Centennial Care. Enrollment with Molina Healthcare may be the result of a recipient's selection or assignment by HSD.

Upon Enrollment with Molina Healthcare, Members receive a Welcome Packet that includes:

- Welcome Letter;
- Member Handbook – The Member handbook contains information advising the Member that the provider directory is available on-line and that assistance with any of the formats may be received by contacting Member Services;
- Provider Directory – The Member is contacted within 30 calendar days of enrollment. At that time, Molina will ask how the Member wants the provider directory provided to them. A CD format will be appropriate if the Member indicates they are computer literate. If the Member is not computer literate, printed copies will be provided to the Member.
- Notice of Privacy Practices;
- Primary Care Provider (PCP) Selection form and postage paid envelope;
- Quit4Life informational brochure; and
- Nurse Advice Line magnet.

Centennial Care Members enrolled with Molina Healthcare of New Mexico are provided with an identification card. The card includes:

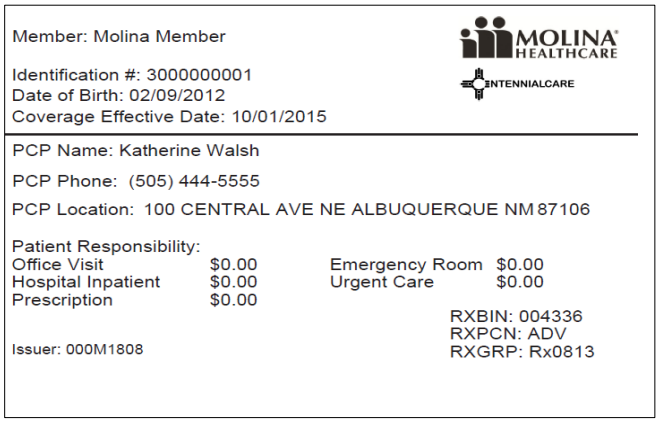
- Telephone numbers for information and/or authorizations, including for physical health, behavioral health, and long-term care services;
- Descriptions of procedures to be followed for emergency or special services;
- Member identification number, name, date of birth, enrollment effective date, and PCP; and
- Member co-payment amounts for covered services.

The back of Molina Healthcare's Member identification card provides important information on obtaining services and telephone numbers for our providers and Members to utilize as needed.

At each office visit, your office staff should:

- Ask for the Member's ID Card;
- Copy both sides of the ID Card and keep the copy with the patients files; and
- Determine if the Member is covered by another health plan, and record information for coordination of benefits. If the Member is covered by another health plan, the provider must submit to the other carrier(s) first. After the other carrier(s) pay, submit the claim to Molina Healthcare.

Sample of Molina Healthcare of New Mexico Centennial Care ID Card:



Members, due to their category of eligibility based on income-level, may qualify for the Alternative Benefit Plan, which has copayment requirements for some covered services. Copayments will be reflected on the Member ID Card and can be found on the Provider Web Portal.

C. PCP Assignment

After a Member has been enrolled for 15 calendar days, a primary care practitioner (PCP) is assigned to the Member with the exception of Dual Eligible Members (enrolled in both Medicaid and Medicare who are assigned or have previously selected a PCP accepting Medicare). The Member will receive an identification card showing the assigned PCP. ID cards for Dual Eligible Members will not reflect a PCP. Individual family Members may choose the same or different PCPs.

Members may chose a PCP from the list of participating practitioners in one of the following specialties:

- Family Practice, General Practice;
- Certified Nurse Practitioner and Physician Assistants;
- Internal Medicine;
- Gerontology;
- Pediatrics;
- OB/GYN – Female Members may self-refer to a women's health care provider. Some OB/GYNs act as a PCP. In this case, the OB/GYN is listed under the Primary Care Section of the Provider Directory; and
- Specialists, on an individualized basis, for Members whose care is more appropriately managed by a specialist, such as Members with infectious diseases, chronic illness, etc. A board-certified psychiatrist may serve as a PCP for Members with complex behavioral health conditions or disabilities.
- I/T/Us (Indian Health Services, Tribal 638 and Urban Indian Providers may be designated as PCPs as appropriate.

D. Change in PCP Assignment

1. Member Initiated

The Member has the right to change that PCP and may call Molina Healthcare with the change request. When a Member changes PCPs, Molina Healthcare will issue a new identification card to the Member. Members may initiate a PCP change at any time, for any reason. The request for PCP change may be made in writing or by telephone. If the change is requested by the twentieth of the month, it will become effective the first day of the following month. If the request is made after the twentieth day, it will become effective the first day of the second month following the request.

Members presenting at a PCP's office **to whom they are not assigned,** may request a change of PCP by filling out and signing a "Member Authorization to Change Primary Care Practitioner" Form. The form should then faxed or emailed to Molina Healthcare and a new identification card will be sent to the Member. This form may be found at PCP Change Form

2. **PCP Initiated**
   Molina Healthcare asks that you document the need for these changes in writing to the Provider Services Department, with the specific reasons for the request. **Reasonable Cause Does Not Include a Member's Health Status.** Please submit documentation to:

   Molina Healthcare of New Mexico, Inc.
   Provider Services Department
   P. O. Box 3887
   Albuquerque, NM, 87190 - 9859 OR
   Fax to (505) 798-7313

   PCPs are responsible for providing basic care and emergency coverage for up to thirty (30) days after the date of your change letter, or until we can confirm the Member has made a change in his/her PCP, whichever is less. The PCP initiating the Member's change is responsible for the copy and transfer of the Member's medical records to the new PCP.

3. **Molina Healthcare Initiated Change of PCP**
   Molina Healthcare may initiate a PCP change for a Member under the following circumstances:
   a. Molina Healthcare and the Member agree that assignment to a different PCP is in the Member's best interest, based on the Member's medical condition;
   b. A Member's PCP ceases to be a Molina-contracted practitioner;
   c. A Member's behavior towards the PCP is such that it is not feasible to safely or prudently provide medical care, and the PCP has made reasonable efforts to accommodate the Member;
   d. A Member has initiated legal actions against the PCP;
   e. The PCP is suspended for any reason; and /or
   f. Based on claims data, Members will be automatically reassigned to the PCP they are actually visiting, rather than the one initially assigned through the PCP auto assignment process. This "re-paneling" process will be executed on the 20th of each month. Establishing accurate panels will allow Molina Healthcare to appropriately measure primary care utilization, capacity, assess patient characteristics, and generate clinical quality indicators based on an accurate denominator. This will also allow Molina Healthcare staff and the Member's PCP to better direct outreach and quality initiatives to the appropriate Members.

4. **PCP/Medical Practitioner Lock-In**
   When concerns about misuse of unnecessary services and/or prescription drugs by a Member are identified, Molina Healthcare may place a Member into "lock-in." This program is called Patient Review and Restriction (PRR). Enrollment in the PRR Program is usually for twelve months.

   PCP Lock-In:
   Molina Healthcare may require that a Member see a certain PCP while ensuring reasonable access to quality services when:

- Utilized services have been identified as unnecessary;
- A Member's behavior is detrimental; and/or
- A need is indicated to provide care continuity.

Molina Healthcare utilizes claims data, emergency room reports, pharmacy claims reports, New Mexico Prescription Monitoring Program reports, Care Coordination Referral Forms, Provider Complaints and Nurse Advice Line reports to identify when a Member's behavior requires placement into Lock-In.

Identified behaviors include, but are not limited to: excessive emergency room utilization, excessive PCP change requests, provider reports of drug demands when not medically indicated and non-compliance to treatment plans, self-referral to pain management providers, and excessive "no-shows" to provider appointments.

A Member may be considered for lock-in/PRR if their utilization history shows:

a. Any of the following conditions have been met or exceeded in a ninety-day period within the past year:
    - The Member has received services from four or more different practitioners, or
    - Has had controlled substance prescriptions filled by three or more different pharmacies, or
    - Has received excessive prescriptions and/or quantities of controlled substances as documented in Rx claims history and/or NM Prescription Monitoring Program reports, or
    - Has received controlled substance prescriptions from three or more different prescribers not in the same medical practice especially emergency department providers, or
    - Has received opioid prescriptions while on opioid replacement therapy.
    - Has received similar services from two or more practitioners in the same day; or
b. The Member has made two or more visits to emergency departments for similar services within a 90-day period in the past year; or
c. The Member has a medical history at-risk utilization patterns within the past year; or
d. The Member has made repeated and documented efforts to seek medically unnecessary health services within the past year; and has been counseled at least once by a health care provider or managed care plan representative about the appropriate use of health care services.

When the conditions listed above are met, a medical director reviews the Member's diagnosis, history of services provided, or other relevant medical information (e.g., prescription claims history). The Medical Director must determine that the documented utilization shows both of the following:

- That the utilization is all related to one problem, and is not an unlucky coincidence of appropriate treatment for several different problems; and
- That continuation of services from multiple providers constitutes inappropriate, unsafe, or medically unnecessary medical practice or overuse of medical services (as defined

in applicable New Mexico statutes and regulations) medical services well beyond the patient's medically necessary care).

If the reviewing medical director finds that the Member is using inappropriate, unsafe, or medically unnecessary services, Molina Healthcare staff will follow policies and procedures to initiate restrictions.

Prior to placing a Member into medical provider lock-in, Molina will inform the Member and/or Member's Representative of the intent to lock-in, including the reasons for imposing the lock-in and notice that the restriction does not apply to emergency services furnished to the Member.

a. Molina Healthcare's grievance procedure will be made available to any Member being designated for PCP lock-in.
b. The PCP lock-in will be reviewed, documented and reported to HSD every month.
c. The Member will be removed from PCP lock-in when it has determined that the utilization problems have been solved and that recurrence of the problems is judged to be improbable.
d. HSD will be notified of all lock-in removals.

The Member's input will be required to select an assigned medical practitioner for lock-in. Depending on circumstances, this practitioner may be the Member's PCP, pain specialist, oncologist, Suboxone or methadone provider or another medical practitioner who has a relationship with the Member and a reason to provide the Member with prescriptions for drugs with abuse potential. The medical practitioner chosen by the Member must be agreeable to acting as the practitioner and manager of the Member's prescriptions for medications with abuse potential. Molina Healthcare's grievance procedure will be made available to a Member disagreeing with the lock-in process.

The lock-in will be reviewed and documented by Molina Healthcare and reported to HSD every month. The Member will be removed from lock-in when Molina Healthcare has determined that the utilization problems or detrimental behavior has ceased and that recurrence of the problems is judged to be improbable. HSD will be notified of all lock-in removals.

Criteria for ending lock-in/PRR for a Member are as follows:

a. The Member has been in the program for 12 months, and
b. Review of clinical, prescribing, and billing information shows that the Member's care has been reasonable and appropriate, or
c. The PCP handling the lock-in/PRR restrictions reports that the services requested have been reasonable and appropriate, or
d. One of the following early-termination criteria are met:
e. The Member disenrolls or otherwise leaves the plan; or
f. The Member's health status changes and the program is no longer necessary or is a hindrance to ongoing medical care.

5. **Member Disenrollment**
   A Member may request to be disenrolled from Molina Healthcare for cause at any time, even during a lock-in period. The Member must submit a written request to HSD for approval.

E. Transition of Care for New Molina Healthcare Members

Molina Healthcare will authorize medically necessary health care services for a new Member who has been authorized to receive these services by their previous Medicaid health plan, the Health Insurance Marketplace and/or fee-for-service Medicaid upon enrollment to Molina Healthcare as defined by State regulation.

The utilization reviewer and/or care manager will contact the new Member and the new Member's current practitioner/provider to determine the transition of care needs of the Member to a Molina Healthcare contracted practitioner/provider.

F. Continuity of Care

1. **Continuity of Care Following Transition Between two Managed Care Organizations (MCOs)**
   Practitioners/providers will receive pertinent Member information, with Member consent, when the Member transitions from one managed care organization to another, including information related to key medical conditions, authorization data, assessment results, and service coordination and/or care management status, including a copy of the current Care Plan.

2. **Continuity of Care Following Member Loss of Eligibility**
   If the Member's eligibility ends and the Member needs continued treatment, Molina Healthcare will inform the Member of alternative options for care that may be available through a local or state agency.

3. **Continuity of Care and Communication after Practitioner Termination**
   The provider leaving the network will provide all appropriate information related to course of treatment, medical treatment, etc. to the provider(s) assuming care. 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.

   a. Molina Healthcare allows any Member whose treating practitioner leaves the network during an episode of care, to continue diagnostic or therapeutic endeavors with that practitioner until the current episode of care (an active course of treatment for an acute medical condition or ongoing treatment of a chronic medical condition) terminates or until ninety (90) days have elapsed since the practitioner's contract ended, whichever is shorter;
   b. Molina Healthcare will authorize this continuity of care only if the health care practitioner/provider agrees to:

- Accept reimbursement from Molina Healthcare at the rates applicable prior to the start of the transitional period as payment in full; and
- Adhere to Molina Healthcare's quality assurance requirements and to provide to Molina Healthcare necessary medical information related to such care.

Under no circumstances will Members be permitted to continue care with practitioners/providers who have been terminated from the network for quality of care, barred from participation based on existing Medicare, Medicaid or Health Insurance Marketplace sanctions (except for Emergency Services) or fraud reasons.

G. Member Notification of PCP and Specialist Termination

Molina Healthcare will notify Members in writing of their PCP's termination within thirty (30) calendar days of the receipt of the termination. A notification will be sent to a Member if they have seen a PCP within the last 90 days even if he/she was not assigned to the terminating provider. A new Molina Healthcare identification card is mailed to the Member reflecting their choice of a new PCP or assignment to a new PCP.

Molina Healthcare will notify the Member in writing of their specialist's termination when the Member has received services from that specialist within the ninety (90) days immediately prior to the specialist's termination.

Molina Healthcare Care Coordinators will work with providers to gather information needed to create a transition plan, some of which is required to submit to the New Mexico Human Services Department if the termination of any one provider is deemed substantial.

H. Member Health Assessment

Molina Healthcare will identify Members with complex physical and/or behavioral health needs through screening and health assessments performed by Care Managers at the time of enrollment. The staff will obtain basic health demographic information to complete a Health Risk Assessment (HRA). The HRA results will determine the necessary level of care management, identify any cultural or disability sensitivities and determine the need for a Comprehensive Needs Assessment (CNA).

The results of the HRA will be communicated to Molina Healthcare's Care Management team for evaluation of the appropriate level of care and any special accommodations. Members identified will be referred for the appropriate level of Care Management and Care Coordination, and a Molina Healthcare Care Manager will develop a Care Plan to address the Members functional needs, medical conditions, behavioral health needs, and social and environmental needs in collaboration with the Member's family, PCP, and other professional practitioners/providers or agencies involved in their care.

The Care Coordination Queue is available during normal business house Monday through Friday from 8:00 a.m. – 5:00 p.m. Please call or refer Members to **toll free (855) 315-5677. will**

I. Molina Healthcare Initiated Disenrollment of Member

Molina Healthcare may request disenrollment of a Member from its health plan when:

1. A good faith effort has been made to accommodate the Member and address the Member's problems but those efforts have been unsuccessful;
2. The conduct of the Member does not allow Molina Healthcare to safely or prudently provide medical, behavioral and/or long-term care subject to the terms of its contract with HSD;
3. Molina Healthcare has offered to the Member in writing the opportunity to use its grievance procedures;
4. Molina Healthcare has received threats or attempts of intimidation from the Member to its staff or to practitioners or their staff.

Disenrollment will not be requested because of an adverse change in the Member's health status or because of the Member's utilization of services, diminished mental capacity or uncooperative or disruptive behavior resulting from the Member's special needs, except when continued enrollment seriously impairs the ability to furnish services to either the Member or other Members.

Section 4 - Member Rights and Responsibilities

All contracted Molina Healthcare providers must abide by the Member rights and responsibilities as outlined below.

A. Member Rights

- Members or their legal guardians have a right to receive information about Molina Healthcare, Molina Healthcare's policies and procedures regarding products, services, its contracted practitioners and providers, grievance procedures, benefits provided and Member rights and responsibilities;
- Members have a right to be treated with courtesy and consideration, equitably and with respect and recognition of their dignity and right and need for privacy;
- Members or their legal guardians have a right to choose a primary care practitioner (PCP) within the limits of the covered benefits and plan network, and the right to refuse care of specific practitioners or to notify the provider if changes need to be requested;
- Members or their legal guardians have a right to receive from the Member's practitioner/provider, in terms that the member or legal guardian(s) understands, an explanation of his or her complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives, irrespective of the health care insurer's or Molina Healthcare's position on treatment options. If the Member is not capable of understanding the information, the explanation be provided to his or her next of kin, guardian, agent or surrogate, if available, and documented in the member's medical record;
- Members have a right to receive health care services in a non-discriminatory fashion;
- Members who do not speak English as their first language have the right to access translator services at no cost for communication with Molina Healthcare;
- Members who have a disability have the right to receive information in an alternative format in compliance with the Americans with Disabilities Act;
- Members or their legal guardians have a right to participate with their health care practitioner/provider in decision making in all aspects of their health care, including the treatment plan development, acceptable treatments and the right to refuse treatment;
- Members or their legal guardians have the right to informed consent;
- Members or their legal guardians have the right to choose a surrogate decision-maker to be involved, as appropriate, to assist with care decisions;
- Members or their legal guardians have the right to seek a second opinion by another provider in the Molina Healthcare network when Members need additional information regarding recommended treatment or believe the provider is not authorizing requested care;
- Members have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage;
- Members or their legal guardians have a right to voice complaints, grievances or appeals about Molina Healthcare, the handling of grievances, or the care provided and make use of Molina Healthcare's grievance process and the Human Service Department (HSD) hearings process, at no cost, without fear of retaliation;
- Members or their legal guardians have a right to file a complaint, grievance or appeal with Molina Healthcare or the HSD Administrative Hearings Bureau, for Medicaid Members,

and to receive an answer to those complaints, grievances or appeals within a reasonable time;

- Members or their legal guardians have a right to choose from among the available practitioners and providers within the limits of Molina Healthcare's network and its referral and prior authorization requirements;
- Members or their legal guardians have a right to make their decisions known through advance directives regarding health care decisions (i.e., living wills, right to die directives, "do not resuscitate" orders, etc.) consistent with federal and state laws and regulations;
- Members or their legal guardians have a right to privacy of medical and financial records maintained by Molina Healthcare and its providers, in accordance with existing law;
- Members or their legal guardians have a right to access the Member's medical records in accordance with the applicable federal and state laws and regulations;
- Members have the opportunity to consent to or deny the release of identifiable medical or other information by Molina Healthcare, except when such release is required by law;
- Members have a right to request an amendment to their Protected Health Information (PHI) if the information is believed to be incomplete or wrong;
- Members or their legal guardians have a right to receive information about Molina Healthcare, its health care services, how to access those services, the network practitioners and providers (i.e., title and education) and the Patient Bill of Rights;
- Members or their legal guardians have a right to be provided with information concerning Molina Healthcare's policies and procedures regarding products, services, practitioners and providers, appeal procedures, obtaining consent for use of Member medical information, allowing members access to their medical records, and protecting access to member medical information, and other information about Molina Healthcare and benefits provided;
- Members or their legal guardians have a right to know upon request of any financial arrangements or provisions between Molina Healthcare and its practitioners and providers which may restrict referral or treatment options or limit the services offered to Members;
- Members or their legal guardians have a right to be free from harassment by Molina Healthcare or its network practitioners or providers in regard to contractual disputes between Molina Healthcare and practitioners or providers;
- Members or their legal guardians have a right to available and accessible services when medically necessary as determined by the primary care practitioner (PCP) or treating provider in consultation with Molina Healthcare, twenty-four (24) hours per day, seven (7) days per week for urgent or emergency care services, and for other health care services as defined by the contract or evidence of coverage;
- Members have a right to adequate access to qualified health professionals near where the Member lives or works, within the service area of Molina Healthcare;
- Members have a right to affordable health care, with limits on out-of-pocket expenses, including the right to seek care from a non-participating Provider, and an explanation of a Member's financial responsibility when services are provided by a non-participating provider/ or non-participating practitioner, or provided without required pre-authorization;
- Members or their legal guardians have a right to prompt notification of termination or changes in benefits, services or Provider network;

- Members have a right to seek care from a non-participating provider and be advised of their financial responsibility if they receive services from a non-participating provider, or receive services without required Prior Authorization;
- Members have the right to continue an ongoing course of treatment for a period of at least thirty (30) calendar days. This will apply if the Member's provider leaves the Provider network, or if a new Member's provider is not in the Provider network;
- Members have the right to make recommendations regarding the organization's Member Rights and Responsibilities policy;
- Members have a right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion;
- Members or their legal guardians will have the right to select a Managed Care Organization (MCO) and exercise switch enrollment rights without threats or harassment;
- Members have a right to detailed information about coverage, maximum benefits and exclusions of specific conditions, ailments or disorders, including restricted benefits and all requirements that an enrollee must follow for prior approval and utilization review;
- Members or their legal guardians have all the rights afforded by law, rule, or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the Member understands;
- Members or their legal guardians have the right to a complete explanation of why care is denied, an opportunity to appeal the decision to Molina Healthcare's internal review, the right to a secondary appeal, and the right to request the superintendent's or HSD's assistance as applicable;
- Members or their legal guardians have the right to get information, when they ask, that HSD determines is important during the Member's first contact with the MCO. This information can include a request for information about the MCO's structure, operation and/or practitioners or senior staff's incentive plans; and
- Members or their legal guardian are be free to exercise his/her rights and that exercising those rights will not result in adverse treatment of the Member or their legal guardian.

B. Member Responsibilities

Molina Healthcare enrolled Members and/or his/her guardian(s) has the responsibility to:

1. Provide, to the extent possible, information that Molina Healthcare and its providers need in order to care for him/her.
2. Understand the Member's health problems and to participate in developing mutually agreed upon treatment goals.
3. Follow the plans and instructions for care that he/she have agreed on with his/her practitioner(s).
4. Keep, reschedule or cancel an appointment rather than to simply fail to show-up.
5. Review his/her Member Handbook or Evidence of Coverage and if there are questions contact the Member Services Department for clarification of benefits, limitations and exclusions. The Member Services telephone number is located on the Member's Identification Card.

6. Follow Molina Healthcare's policies, procedures and instructions for obtaining services and care.
7. Show his/her Member Identification Card each time he/she goes for medical care and to notify Molina Healthcare immediately of any loss or theft of his/her identification card.
8. Advise a participating provider of coverage with Molina Healthcare at the time of service. Members may be required to pay for services if he/she does not inform the participating provider of his/her coverage.
9. Pay for all services obtained prior to the effective date with Molina Healthcare and subsequent to termination or cancellation of coverage with Molina Healthcare.
10. Notify his/her Income Support Division Caseworker if there is a change in his/her name, address, telephone number, or any changes in his/her family.
11. Notify HSD and Molina Healthcare if he/she gets medical coverage other than through Molina Healthcare.
12. Pay for all required co-payments and/or coinsurance at the time services are rendered.

Section 5 – Centennial Care Covered Services

Molina Healthcare provides and coordinates comprehensive and integrated health care benefits to each of its enrolled Members and covers the physical health, behavioral health and long-term care benefits as directed by HSD.

A. Community Benefit

For Members meeting nursing facility level of care, Molina Healthcare provides the Community Benefit, as determined appropriate based on the Member's Comprehensive Needs Assessment. The **Community Benefit** means both the **Agency-Based Community Benefit and the Self-Directed Community Benefit** subject to an individual's annual allotment as determined by HSD. Members eligible for the Community Benefit will have the option to select either the Agency- Based Community Benefit or the Self-Directed Community Benefit.

- Members selecting the Agency-Based Community Benefit will have the option to select their personal care service provider; and
- Members may also select the Self-Directed Community Benefit, which affords them the opportunity to have choice and control over how services are provided and how much certain providers are reimbursed in accordance with range of rates per service established by HSD.

Agency-Based Community Benefit Services
Adult Day Health
Assisted Living
Behavior Support Consultation
Community Transition Services
Emergency Response
Employment Supports
Environmental Modifications
Home Health Aide
Personal Care Services
Private Duty Nursing for Adults
Respite
Skilled Maintenance Therapy Services
Self-Directed Community Benefit Services
Behavior Support Consultation
Customized Community Support
Emergency Response
Employment Supports
Environmental Modifications
Home Health Aide
Homemaker/Personal Care
Nutritional Counseling
Private Duty Nursing for Adults
Related Goods

Respite
Skilled Maintenance Therapy Services
Specialized Therapies
Transportation (non-medical)

B. Tale of Centennial Care Non-Community Benefit Covered Services

Non-Community Benefit Services
Accredited Residential Treatment Center Services
Adult Psychological Rehabilitation Services
Ambulatory Surgical Center Services
Anesthesia Services
Applied Behavior Analysis
Assertive Community Treatment Services
Behavior Management Skills Development Services
Behavioral Health Professional Services: outpatient behavioral health and substance
Case Management
Community Interveners for the Deaf and Blind
Comprehensive Community Support Services
Day Treatment Services
Dental Services
Diagnostic Imaging and Therapeutic Radiology Services
Dialysis Services
Durable Medical Equipment and Supplies
Emergency Services (including emergency room visits and psychiatric ER)
Experimental or Investigational Procedures, Technology or Non-Drug Therapies[1]
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
EPSDT Personal Care Services
EPSDT Private Duty Nursing
EPSDT Rehabilitation Services
Family Planning
Family Support (Behavioral Health)
Federally Qualified Health Center Services
Hearing Aids and Related Evaluations
Home Health Services
Hospice Services
Hospital Inpatient (including detoxification services)
Hospital Outpatient
Inpatient Hospitalization in Freestanding Psychiatric Hospitals
Intensive Outpatient Program Services
IV Outpatient Services
Laboratory Services
Medication Assisted Treatment for Opioid Dependence
Midwife Services
Multi-Systemic Therapy Services

Non-Accredited Residential Treatment Centers and Group Homes
Nursing Facility Services
Nutritional Services
Occupational Services
Outpatient Hospital based Psychiatric Services and Partial Hospitalization
Outpatient and Partial Hospitalization in Freestanding Psychiatric Hospital
Outpatient Health Care Professional Services
Pharmacy Services
Physical Health Services
Physical Therapy
Physician Visits
Podiatry Services
Pregnancy Termination Procedures
Preventive Services
Prosthetics and Orthotics
Psychosocial Rehabilitation Services
Radiology Facilities
Recovery Services (Behavioral Health)
Rehabilitation Option Services
Rehabilitation Services Providers
Reproductive Health Services
Respite (Behavioral Health)
Rural Health Clinics Services
School-Based Services
Smoking Cessation Services
Speech and Language Therapy
Swing Bed Hospital Services
Telehealth Services
Tot-to-Teen Health Checks
Transplant Services
Transportation Services (medical)
Treatment Foster Care
Treatment Foster Care II
Vision Care Services

[1]Experimental and investigational procedures, technologies or therapies are only available to the extent specified in MAD 8.325.6.9 or its successor regulation.

C. Table of Alternative Benefit Plan (ABP) - Covered Services

Alternative Benefit Plan Services Included Under Centennial Care
Allergy testing and injections
Annual physical exam and consultation[1]

[1] Includes a health appraisal exam, laboratory and radiological tests and early detection procedures.

Autism spectrum disorder (through age 22)[2]
Bariatric surgery[3]
Behavioral health professional and substance abuse services, evaluations, testing, assessments, therapies and medication management
Cancer clinical trials
Cardiac rehabilitation[4]
Chemotherapy
Dental services[5]
Diabetes treatment, including diabetic shoes, medical supplies, equipment and education
Dialysis
Diagnostic imaging
Disease management
Drug/Alcohol dependency treatment services, including outpatient detoxification, therapy, partial hospitalization and intensive outpatient program (IOP) services
Durable medical equipment, medical supplies, orthotic appliances and prosthetic devices, including repair or replacement[6]
Electroconvulsive therapy
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, including routine oral and vision care, for individuals age 19 and 20
Emergency services, including emergency room visits, emergency transportation, psychiatric emergencies and emergency dental care
Family planning and reproductive health services and devices, sterilization, pregnancy termination and contraceptives[7]
Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) services
Genetic evaluation and testing[8]
Habilitative and rehabilitative services, including physical, speech and occupational therapy[9]

[2] Covers speech, occupational and physical therapy, and applied behavioral analysis for recipients age 19-20; or age 21-22 who are enrolled in high school.

[3] Limited to one per lifetime. Criteria may be applied that considers previous attempts by the member to lose weight, BMI and health status.

[4] Limited to short-term therapy (two consecutive months) per cardiac event.

[5] The ABP covers dental services for adults in accordance with 8.3.10.7 NMAC. Recipients age 19-20 may receive dental services according to the increased periodicity under EPSDT.

[6] Requires a provider's prescription. DME is limited to a periodicity schedule and must be medically necessary. Disposable medical supplies are limited to diabetic and contraceptive supplies. Foot orthotics, including shoes and arch supports, are covered only when an integral part of a leg brace, or are diabetic shoes.

[7] Sterilization reversal is not covered. Infertility treatment is not covered.

[8] Limited to Triple Serum Test and genetic testing for the diagnosis or treatment of a current illness. Does not include random genetic screening.

[9] Limited to short-term therapy (two consecutive months) per condition.

Hearing screening as part of a routine health exam[10]
Holter monitors and cardiac event monitors
Home health, skilled nursing and intravenous services[11]
Hospice care services
Hospital inpatient and outpatient services
Immunizations[12]
Inhalation therapy
Inpatient physical and behavioral health hospital/medical services and surgical care[13]
Inpatient rehabilitative services/facilities[14]
IV infusions
Lab tests, x-ray services and pathology
Maternity care, including delivery and inpatient maternity services and pre- and post-natal care
Mammography, colorectal cancer screenings, pap smears, PSA tests and other age appropriate tests
Medication assisted treatment for opioid dependence
Non-emergency transportation when necessary to secure covered medical services and/or treatment
Nutritional evaluations and counseling – dietary evaluation and counseling as medical management of a documented disease, including obesity
Organ and Tissue Transplants[15]
Osteoporosis diagnosis, treatment and management
Outpatient Surgery
Over-the-counter medicines – prenatal drug items and low-dose aspiring as preventive for cardiac conditions[16]

[10] Hearing aids and hearing aid testing by an audiologist or hearing aid dealer are not covered, except for recipients age 19-20.

[11] Home health is limited to 100 visits per year. A visit cannot exceed four hours.

[12] Includes ACIP-recommended vaccines

[13] Includes services in a psychiatric unit of a general hospital and inpatient substance abuse detoxification. The ABP does not include inpatient drug rehabilitation services. Free-standing psychiatric hospitals (or Institutions for Mental Disease) are not covered under the ABP or ABP-exempt package except for recipients age 19-20. Surgeries for cosmetic purposes are not covered.

[14] Includes services in a nursing or long-term care acute rehabilitation facility/hospital. Covered is limited to temporary stays as a step-down level of care from an acute care hospital when medically necessary and the discharge plan for the recipient is the eventual return home.

[15] Transplants are limited to two per lifetime.

[16] Other over-the-counter items may be considered for coverage only when the item is considered more medically or economically appropriate than a prescription drug, contraceptive drug or device, or for treating diabetes.

Periodic age-appropriate testing and examinations – glaucoma, colorectal, mammography, pap tests, stool, blood, cholesterol, and other preventive/diagnostic care and screenings[17]
Physician visits
Podiatry and foot care[18]
Prescription medicines
Primary care to treat illness/injury
Pulmonary therapy[19]
Radiation therapy
Reconstructive surgery for the correction of disorders that result from accidental injury, congenital defects or disease
Skilled nursing[20]
Sleep studies[21]
Smoking cessation treatment
Specialist visits
Specialized behavioral health services for adults: Intensive Outpatient Programs (IOP), Assertive Community Treatment (ACT) and Psychosocial Rehabilitation (PSR)[22]
Telemedicine services
Urgent care services/facilities
Vision care for eye injury or disease[23]
Vision hardware (eyeglasses or contact lenses)[24]

The Alternative Benefit Plan is a low cost insurance plan for adults ages nineteen (19) to sixty-four (64). Under ABP, there are cost sharing amounts that are based on Federal Poverty Level (FPL) percentages. This will impact newly eligible adults up to 138% of FPL.

[17] Includes US Preventive Services Task Force "A" and "B" recommendations, preventive care and screening recommendations of the HRSA Bright Future program and additional preventive services for women recommended by the Institute of Medicine.

[18] Covered when medically necessary due to malformations, injury, acute trauma or diabetes.

[19] Limited to short-term therapy (two consecutive months) per condition.

[20] Subject to the 100-visit home health limited when provided through a home health agency.

[21] Limited to diagnostic sleep studies performed by certified providers/facilities.

[22] The ABP does not cover behavioral health supportive services: Family Support, Recovery Services and Respite services.

[23] Refraction for visual acuity and routine vision are not covered, except for recipients age 19-20.

[24] Covered only following the removal of the lens from one or both eyes (aphakia). Coverage of materials is limited to one set of contact lenses or eyeglasses per surgery, within 90 days following surgery. Vision hardware is covered for recipients age 19-20 following a periodicity schedule.

Section 6 – Medical Management Program and Prior Authorization

A. Introduction

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.

Molina Healthcare may change the process and/or requirements of its Medical Management Program. Changes will be updated in this Provider Manual and a revised version will be uploaded to the website.

B. Medical Necessity Review

Molina Healthcare only reimburses for services that are Medically Necessary. To determine Medical Necessity, in conjunction with independent professional medical judgment, Molina Healthcare will use nationally recognized guidelines, which include but are not limited to MCG, Interqual®, other third party guidelines, CMS guidelines, state guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks. Medical Necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively.

Medically Necessary means the care which, in the opinion of the treating physician, is reasonably needed to:

- Prevent the onset or worsening of an illness, condition, or disability;
- Establish a diagnosis;
- Provide palliative, curative, or restorative treatment for physical and/or mental health conditions;
- Assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of same age; and
- Not primarily long-term institutional care services unless long-term institutional services is a Covered Service that the Provider has agreed to provide. In addition, there must be no other effective and more conservative or substantially less costly treatment, service and setting available.

Medically Necessary Services means clinical and rehabilitative physical, mental or behavioral health services that are:

1. essential to prevent, diagnose or treat medical conditions or are essential to enable the Member to attain, maintain or regain the Member's optimal functional capacity;
2. delivered in the amount, duration, scope and setting that are both sufficient and effective to reasonably achieve their purposes and clinically appropriate to the specific physical, and behavioral health care needs of the Member;

3. provided within professionally accepted standards of practice and national guidelines;
4. required to meet the physical, and behavioral health needs of the Member; and
5. (not primarily for the convenience of the Member, the provider or Molina Healthcare.

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.

C. 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.

Molina Healthcare may request specific clinical information such as clinical notes, consultation reports, imaging studies, lab reports, hospital reports, letters of medical necessity and other clinical information deemed relevant. All requested information will be on a need-to-know, minimum, necessary basis. Molina Healthcare does not require prior authorization for life- threatening, emergency medical or behavioral health conditions.

D. 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 a copy of the current Authorization Request form. 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 CPT, HCPCS and ICD-10 codes; and
- 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 fourteen (14) calendar days of receipt of request. Urgent requests will be processed within seventy-two (72) hours of receipt

of request.

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.

Emergency Services
Emergency services are covered on a (24) hour basis without the need for prior authorization for all Members experiencing an emergency medical situation. Molina Healthcare 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 contracts with vendors that provide (24) hour emergency services for ambulance and hospitals. In the event that a Member is outside of the service area, Molina Healthcare is prepared to authorize treatment to ensure that the patient is stabilized.

E. Requesting Prior Authorization

The prior authorization (PA) process requires a request to determine medical necessity/eligibility before the service is rendered. To expedite the review process, pertinent clinical notes (i.e. practitioner office notes, medication history, lab test results, etc.) should be attached to the PA request. Authorization for a procedure does not in itself guarantee coverage but notifies you that the procedure as described meets criteria for medical necessity and appropriateness.

1. Practitioners/providers are encouraged to use the Molina Healthcare Web Portal for outpatient (non-pharmacy) prior authorization submission at Web Portal - Provider Self-Serve

   There is a rules-based authorization submission process called Clear Coverage. After logging into the Web Portal, choose the drop down option "Create Service Request/Authorization using Clear Coverage" link under the Service Request/Authorization Menu. Some of the benefits of using Clear Coverage are:
   - Many outpatient services can automatically be approved at the time of the authorization submission;
   - For requests not automatically approved, you can see the real-time status of your request by opening your office's home page directly in Clear Coverage; and
   - Receive rapid confirmation for services where no authorization is required. You are notified within a few steps if no authorization is required for the CPT code requested. You can print or paste a copy of that notification showing no authorization required for your records. There is no need for you to take any additional action.

   When using Clear Coverage, practitioners/providers will receive Auto Approval if criteria is met for the following:
   - Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures;

- Imaging: CT, MRI, MRA, PET, SPECT, Cardiac Nuclear Studies, CT Angiograms, Intimal Media Thickness Testing , Three Dimensional Imaging; and/or
- Genetic Counseling and Testing NOT related to Pregnancy.

If your office/facility would like training to implement the Clear Coverage authorization submission process, please contact your Provider Service Representative. A copy of specific guidelines can be requested by contacting the Health Care Services (HCS) Department or your Provider Service Representative.

2. PA Forms and Services / Codes requiring Prior Authorization may be accessed below or on the Molina Healthcare Provider website at http://www.molinahealthcare.com/providers/nm/medicaid/forms/Pages/fuf.aspx

3. Prior Authorization Requests may also be submitted by fax via the following Toll Free Fax: (888) 802-5711.

   Pharmacy Prior Authorization Requests may be submitted by fax via the following Toll Free Fax: (866) 472-4578.

   Faxes received after 5:00 p.m. Monday through Thursday will be considered to have been received on the next business day. Faxes received after 5:00 p.m. Friday, or on Saturday or Sunday will be considered to have been received on the next business day. Faxes received on a holiday will be considered to have been received on the next business day.

   Medically Urgent Requests by Phone: In Albuquerque: (505) 798-7371 or Toll free (877) 262-0187

4. All authorized services are subject to the Member's benefit plan and eligibility at the time the service is provided. A list of Molina Healthcare's services that require prior authorization are listed below. Routine/Elective requests must be faxed to Molina Healthcare.

Use Clear Coverage for faster turnaround times
Contact Provider Services for details

Referrals to Network Specialists and office visits to contracted (par) providers do not require Prior Authorization

This Prior Authorization/Pre-Service Guide applies to all Molina Healthcare Medicaid and Medicare Members – excludes Marketplace
Refer to Molina's website or portal for specific codes that require authorization
Only covered services are eligible for reimbursement

- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient and Residential Treatment
  - Treatment Foster Care
  - Group Home
  - Electroconvulsive Therapy (ECT)
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD)
- **Cosmetic, Plastic and Reconstructive Procedures (in any setting)**
- **Diapers/Incontinence supplies** (not a Medicare covered benefit)
- **Durable Medical Equipment:** Refer to Molina's Provider website or portal for specific codes that require authorization.
- **Medicare Hearing Supplemental benefit:** Contact Avesis at 1- 800-327-4462
- **Experimental/Investigational Procedures**
- **Genetic Counseling and Testing** except for prenatal diagnosis of congenital disorders of the unborn child through amniocentesis and genetic test screening of newborns mandated by state regulations
- **Home Healthcare and Home Infusion:** After initial evaluation plus six (6) visits **
- **Hyperbaric Therapy**
- **Imaging, Advanced and Specialty Imaging:** Refer to Molina's Provider website or portal for specific codes that require authorization
- **Inpatient Admissions: Acute hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility Long Term Services and Supports:** Refer to Molina's Provider website or portal for specific codes that require authorization. Not a Medicare covered benefit.
- **Non-Par Providers/Facilities: Office visits, procedures, labs, diagnostic studies, inpatient stays except for:**
  - Emergency Department services
  - Professional fees associated with ER visit, approved Ambulatory Surgery Center (ASC) or inpatient stay
  - Local Health Department (LHD) services
  - Other services based on state requirements
- **Occupational Therapy**: After initial evaluation plus twenty-four (24) visits for office, outpatient and home settings **
- **Office-Based Procedures do not require authorization,** unless specifically included in another category (i.e. advanced imaging) that requires authorization even when performed in a participating provider's office
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures:** Refer to Molina's Provider website or portal for specific codes that require authorization
- **Pain Management Procedures:** except trigger point injections (Acupuncture is not a Medicare covered benefit)
- **Physical Therapy:** After initial evaluation plus twenty-four (24) visits for office, outpatient and home settings. **
- **Pregnancy and Delivery:** notification only
  Prosthetics/Orthotics: Refer to Molina's Provider website or portal for specific codes that require authorization
- **Radiation Therapy and Radiosurgery (for selected services only):** Refer to Molina's Provider website or portal for specific codes that require authorization
- **Sleep Studies:** (Except Home sleep studies)
- **Specialty Pharmacy drugs (oral and injectable):** Refer to Molina's Provider website or portal for specific codes that require authorization
- **Speech Therapy:** After initial evaluation plus six (6) visits for office, outpatient and home settings. **
- **Transplants including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization)
- **Transportation:** non-emergent Air Transport
- **Unlisted & Miscellaneous Codes:** Molina requires standard codes when requesting authorization. Should an unlisted or miscellaneous code be requested, medical necessity documentation and rationale must be submitted with the prior authorization request.

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

**** Please be aware that Alternative Benefit Plan members may have restrictions and/or benefit limitations. Please call Molina Healthcare for additional information.**

IMPORTANT INFORMATION FOR MOLINA HEALTHCARE MEDICAID and MEDICARE PROVIDERS

Information generally required to support authorization decision making includes:

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

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

-
- If a request for services is denied, the requesting provider and the member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the provider by telephone, fax or electronic notification. Verbal, fax, or electronic denials are given within one business day of making the denial decision or sooner if required by the member's condition.
- Providers and members can request a copy of the criteria used to review requests for medical services.
- Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician at (800) 377-9594 ext. 180284

Important Molina Healthcare Medicaid and Medicare Contact Information

Prior Authorizations: 8:00 a.m. – 5:00 p.m. (Local time, M-F) Toll Free Phone: 1 (877) 262-0187
Medicaid: Fax: 1 (888) 802-5711
Medicare: Fax - Local (505) 924-8258 Toll Free: 1 (855) 278-0310

Radiology Authorizations:
Phone: 1 (855) 714-2415 Fax: 1 (877) 731-7218

NICU Authorizations:
Phone: 1 (855) 714-2415 Fax: 1 (877) 731-7218

Pharmacy Authorizations:
Medicaid:1 (800) 377-9594 ext. 186336
Medicaid Fax: 1 (866) 472-4578
Medicare Phone: 1 (888) 665-1328
Medicare Fax: 1 (866) 290-1309

Transplant Authorizations:
Phone: 1 (855) 714-2415 Fax: 1 (877) 731-7218

Member Customer Service Benefits/Eligibility:
Medicaid: 1 (800) 580-2811 Fax: (505) 342-0595
Medicare: 1 (866) 440-0127 Fax: 1 (801) 858-0409
TTY/TDD: 1 (800) 346-4128

Behavioral Health Authorizations:
Phone: 1 (855) 315-5677
Toll Free Fax: 1 (888) 295-5494
Local Fax: (505) 924-8237
Secure Email: BHRequests@Molinahealthcare.com

Provider Customer Service: 8:00 a.m. – 5:00 p.m.
Phone: 1 (888) 825-9266

24 Hour Nurse Advice Line
English: 1 (888) 275-8750 [TTY: 1-(866/72935-29]
Spanish: 1 (866) 648-3537 [TTY: 1-866/833-4703]

March Vision Care:
Phone: 1 (888) 493-4070 [TTY: 1-877-627-2480]

Dental:
Medicaid: 1 800-580-2811
Medicare (Avesis): 1 855-214-6779 [TTY: 711]

Transportation:
Medicaid & Medicare: ITM 1 (888) 593-2052

Providers may utilize Molina Healthcare's eWeb at:
https://provider.molinahealthcare.com/Provider/Login

Available features include:

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

Molina Healthcare of New Mexico
Medicaid and Medicare Prior Authorization Request Form
Phone: 1 (877) 262-0187

MEMBER INFORMATION					
Plan:	☐ **Molina Medicaid** **Fax: 1 (888) 802-5711**	☐ **Molina Medicare** **Fax: 1 (505) 924-8258** **Or 1 (855) 278-0310**	☐ **Other:**		
Member Name:			**DOB:**	/ /	
Member ID#:			**Phone:**	( ) -	
Service Type:	☐Elective/Routine		☐Expedited/Urgent*		

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

Referral/Service Type Requested				
Inpatient ☐Surgical procedures ☐Admissions (all types) ☐SNF ☐LTAC	**Outpatient** ☐Surgical Procedure ☐OT ☐PT ☐ST ☐Diagnostic Procedure ☐Hyperbaric Therapy ☐Infusion Therapy ☐Other: _____			☐ Home Health ☐ DME ☐ In Office (Non-Par)
Diagnosis Code & Description:				
CPT/HCPC Code & Description:				
Number of visits requested:		DOS From / / to / /		

Please send clinical notes and any supporting documentation

PROVIDER INFORMATION			
Requesting Provider Name:			
Facility Providing Service:			
Contact at Requesting Provider's office:			
Phone Number:	( ) -	Fax Number:	( ) -
For Molina Use Only:			

F. Criteria Used in Making Medically Necessary Decisions

The Molina Healthcare Quality Assurance Committee (QAC) has approved several criteria sets to be utilized for review of service requests. Molina Healthcare utilizes the Office of Disability Guidelines, and internally developed Molina Clinical Policy documents to determine appropriateness of service requests.

If the requested services do not meet criteria for medical necessity or covered services, the case will be referred to a physician reviewer for determination. Molina Healthcare employs physicians licensed in the State of New Mexico to make medical necessity denial decisions for Centennial Care Members. Board certified physicians from appropriate specialty areas will provide consultations as needed for medical necessity decisions.

Denial decisions are communicated to the provider and the Member, in writing, as required by contract and NCQA standards. These letters include the specific utilization review criteria or benefits provisions used in the determination and provide information on the appeal process. Providers have telephonic access to the Medical Director to discuss medical necessity determinations.

Upon request, Molina Healthcare will provide Utilization Management decision criteria to Members, their families and the public.

G. Second Opinions

As a means of ensuring both high quality health care and Member satisfaction, Molina Healthcare will provide the option for a Member to obtain a second opinion from a qualified health care professional. If an appropriate professional is not available in network, Molina Healthcare will arrange for the Member to obtain the second opinion out of network at no more cost to the Member than if the service was obtained in-network. The Member may obtain a second opinion by:

- Asking his/her PCP for a referral to see another practitioner or specialist to obtain a second opinion medical or surgical services;
- Directly accessing another in-network practitioner; or
- Contacting the Member Service Department in **Albuquerque (505) 342-4681 or toll free (800) 580-2811**, if the practitioner does not agree to a request for a referral for a second opinion.

If a Member requires a second opinion that may only be provided by a practitioner outside the Molina Healthcare network, the referring practitioner will work with Molina Healthcare to obtain the appropriate prior authorization. All out-of-network second opinion requests are reviewed by a Medical Director.

If the practitioner providing the second opinion agrees with the Member's practitioner, Molina Healthcare will not authorize a third opinion. Should the second option differ from the first, the Member may request a third opinion.

The PCP is responsible for coordinating the medical or surgical diagnostic and/or treatment plan if different from the original. The Member's treating behavioral health provider will be

responsible for coordinating the behavioral health treatment.

H. Communication with Providers

Practitioners/providers seeking information about the Utilization Management (UM) process or UM decisions may contact our Health Care Services (HCS) or Pharmacy Management staff between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday. It is Molina Healthcare's policy for staff to identify themselves by name, title and organization when initiating or returning calls regarding UM issues.

Practitioners/providers seeking information regarding medical services may call Member Services in **Albuquerque at (505) 341-7493 or toll free at (888) 825-9266.** If you would like to discuss a case, please ask to be put in contact with one of Molina Healthcare's Medical staff.

I. Ensuring Appropriate Service and Coverage/ Avoiding Conflict of Interest

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. Delegated medical groups/IPAs are required to avoid this kind of conflict of interest.

- Decisions about utilization management (effective use of services) are based only on whether care is appropriate and whether a Member has coverage;
- Molina Healthcare does not reward providers or other individuals for issuing denials of coverage or care;
- UM decision-makers do not receive financial incentives, which encourage review decisions that result in underutilization;
- Molina Healthcare does not reward practitioners/providers or other individuals for issuing denials of coverage or service care; and
- UM decisions-makers do not receive financial incentives.

J. Thirty (30) Day Hospital Readmissions

Definitions:

Readmission: A subsequent admission to an acute care hospital within a specified time frame 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.

Molina Healthcare conducts reviews of acute inpatient admissions that occur within thirty (30) calendar days of a previous initial acute care inpatient admission from the same facility. When such a situation occurs, medical records from the preceding admission will be requested and reviewed in conjunction with clinical documentation from the second admission. If it is determined that the second admission is the result of either premature discharge or of inadequate discharge, transition, or coordination of care, payment for the second admission will be denied. In such instances, please note that the hospital is not allowed to bill the Member.

Hospital readmissions within thirty (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 that occur within thirty 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 Provider, unless it meets one of the exceptions noted below, violates State and/or Federal law or violates the terms of the Hospital or Provider Services Agreement between the Hospital and Molina.

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 (AMA) during the first hospitalization prior to completion of treatment and discharge planning.

K. Timelines for Molina Healthcare Utilization Management Decisions

Type of Request	Molina Decision Timeframes	Molina Notification Timeframes
Non-urgent pre-service decisions (pre-certification routine)	Within 14 calendar days of receipt of request	Within 1 business day of decision
Urgent pre-service Precertification urgent	Within 72 hours of receipt of request **-OR-** Within 1 hour for life threatening conditions	Within 72 hours of receipt of request
Urgent concurrent review (i.e. inpatient, ongoing ambulatory services)	Within 24 hours (equivalent to 1 calendar day) of receipt of request	Within 1 business day of decision
Post-service decisions	Within 30 calendar days of receipt of request	
Residential Services (RTC, TFC, Group Homes)	Within 5 business days of receipt of request	Within 1 business day of decision

L. Initial Inpatient Admission Review

Elective, Non-Urgent Hospitalizations

1. Prior authorization is required for elective, non-urgent admissions, including admissions for elective procedures;
2. Elective inpatient admission services performed without prior authorization may not be eligible for payment.
3. For elective hospitalizations and procedures requiring overnight hospital stay, the facility needs to fax notification toll free to **(888) 802-5711**on the date of admission; and
4. For hospital stays which exceed any pre-approved number of bed days or level of care, concurrent review of medical necessity is required. Records to support concurrent utilization review must be submitted by fax to **(888) 802-5711** within 24 hours – see "Concurrent Inpatient Admission Review" process below.
5. For elective procedures and for scheduled, non-emergent hospitalizations, please refer to the Prior Authorization Guide above. The request and the relevant clinical information submitted are evaluated and reviewed against established criteria to determine the medical necessity and appropriateness of an inpatient stay and proposed treatment plan.
6. Only patients with a medical need for hospitalization are approved for admission;
7. The proposed treatment is customary for the diagnosis; and
8. Treatment will take place in the most cost effective and appropriate setting.

Urgent/EmergentHospitalizations

1. Molina Healthcare requires notification of all emergent inpatient admissions within twenty-four (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 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. The facility/practitioner must fax admission notification toll free to **(888) 802-5711;**
2. All weekend and/or holiday inpatient or hospital observation admissions are subject to retrospective review for medical necessity;
3. For admissions over the weekend/holiday, facility reviews are expected to contain appropriate clinical evidence of services administered over the weekend/holiday;
4. Concurrent utilization review is required for all contracted facilities. Review documentation is to be faxed toll free to **(888) 802-5711** within 24 hours, refer to "Concurrent Inpatient Admission Review" process below;
5. The Medical Director, may call the attending practitioner for more information if questions arise relating to the admission;
6. When coverage is denied based on lack of medical necessity, Molina Healthcare will notify the requesting facility and send a confirmatory denial letter;
7. All medical necessity denials are made by a Molina Medical Director;
8. The attending physician or hospital (with the Member's written consent), the Member or Member's representative may appeal a denial within ninety (90) calendar days; and
9. If the request is of an emergent/urgent nature then the attending physician, hospital, Member or Member's representative can request an expedited appeal.

Labor & Delivery

1. Molina Healthcare does not require notification for "normal" labor and delivery stays

(forty- eight (48) hours for vaginal delivery and ninety-six (96) hours for cesarean (C-sections) or for stays less than twenty-four (24) hours. If the newborn is not discharged with the mother and requires a longer stay, authorization is required; and

2. If the newborn is in a higher acuity bed than newborn nursery, authorization is required.

Notification of Birth (MAD Form 313) must be completed by the hospital (or other Medicaid provider) prior to the time of discharge to ensure that Medicaid eligible newborn infants are enrolled into Centennial Care. The child will be enrolled in the same Managed Care Organization (MCO) as the enrolled mother.

M. Nursing Facility Admissions /Discharges

Practitioners/Providers are required to promptly notify Molina Healthcare of a:

- Member's admission or request for admission to the Nursing facility regardless of payer source for the Nursing Facility stay;
- Change in a Member's known circumstances; and
- Member's pending discharge (must be in writing).

N. Concurrent Inpatient Admission Review

Contracted facilities are required to participate in providing documentation to support concurrent utilization review of acute hospital admissions. Documentation supporting medical necessity for hospitalization will be submitted for review by Molina Healthcare HCS staff by no later than twenty-four (24) hours after (1) admission or (2) re-review date as specified by Molina Healthcare HCS staff. Failure to submit such documentation within the specified twenty-four hour (24-hour) timeframe will result in administrative denial of coverage. In such instances, please note that the hospital is not allowed to bill the Member.

Records to support utilization review of initial and ongoing hospital stays should include documentation by the attending physician and other medical professionals providing care for the Member. Appropriate documents for submission include History and Physicals, physician's progress notes, results of pertinent laboratory and imaging studies, vital signs, consultant notes and discharge summaries.

O. On Site Review

Some facilities may receive on-site review by Molina Healthcare staff. When Healthcare staff Members arrive at your facility, they are required to identify themselves by name, title and organization. They should also be wearing his/her Molina Healthcare photo identification badge.

P. Non-Contracted Practitioners and Facilities

Molina Healthcare maintains a contracted network of qualified healthcare 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.

For all admissions to non-contracted facilities, which were not pre-approved through Molina Healthcare, retrospective review is required and documentation is to be submitted at the time of claim submission.

Q. Provider Preventable Conditions and Present on Admission Program

Molina Healthcare follows procedures for coverage of Provider Preventable Conditions as specified by the State of New Mexico and the Centers for Medicare and Medicaid Services. From the State of NM Medical Assistance Program Supplement 12-05:Federal regulations released by the Centers for Medicare and Medicaid Services (CMS) on June 6, 2011 outlined the final requirements regarding *Payment Adjustment for Provider- Preventable Conditions Including Health Care-Acquired Conditions.* These regulations implemented Section 2702 of the Affordable Care Act (ACA, P.L. 111-148 and P.L. 111- 152), which requires the Secretary of Health and Humans Services (HHS) to issue regulations prohibiting federal payments to states for providing medical assistance for Provider Preventable Conditions (PPCs), effective July 1, 2011. The final rule requires that state Medicaid programs implement non-payment polices for provider preventable conditions (PPCs) including health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs).

1. **Provider Preventable Conditions – Hospital-Acquired Conditions**

   One category of PPCs is Hospital Acquired Conditions (HACs), which apply to all inpatient settings. Effective July 1, 2012, the New Mexico Medicaid Program is adopting the CMS present on admission (POA) / Hospital-Acquired Conditions (HAC) policy and will begin to deny claims that indicate that the diagnosis was not present on admission or that the documentation is insufficient to determine if condition was present at the time of inpatient admission. Conditions / diagnosis codes are identified by CMS as

   HACs when not present on hospital admission. The following are conditions or events considered to be HACs:

   a. Foreign Object Retained After Surgery;
   b. Air Embolism;
   c. Blood Incompatibility;
   d. Stage III and IV Pressure Ulcers;
   e. Falls and Trauma; including Fractures, Dislocations, Intracranial Injuries , Crushing Injuries, Burns, Electric Shock;
   f. Catheter-Associated Urinary Tract Infection (UTI);
   g. Vascular Catheter-Associated Infection;
   h. Manifestations of Poor Glycemic Control; including: Diabetic Ketoacidosis, Nonketotic Hyperosmolar Coma, Hypoglycemic Coma, Secondary Diabetes with Ketoacidosis, Secondary Diabetes with Hyperosmolarity; and
   i. Surgical Site Infection Following:
      - Coronary Artery Bypass Graft (CABG) – Mediastinitis;
      - Bariatric Surgery; including Laparoscopic Gastric Bypass, Gastroenterostomy, Laparoscopic Gastric Restrictive Surgery;
      - Orthopedic Procedures; including Spine, Neck, Shoulder, Elbow; and
      - Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Total Knee

Replacement or Hip Replacement with pediatric and obstetric exceptions.

2. **Reporting the Present on Admission Indicator**
   Practitioners/providers must follow the official POA coding guidelines as set forth in the *UB- 04 Data Specifications Manual* and in the *ICD Official Guidelines for Coding and Reporting*, or their successors. Present on admission is defined as present at the time the order for inpatient admission occurs - conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.

   POA indicator is assigned to principal and secondary diagnoses (as defined in Section II of the *Official Guidelines for Coding and Reporting*) and the external cause of injury codes. Issues related to inconsistent, missing, conflicting or unclear documentation must still be resolved by the provider. If a condition would not be coded and reported based on Uniform Hospital Discharge Data Set definitions and current Official Guidelines, then the POA indicator would not be reported. Providers of inpatient DRG claims will be required to use the "present on admission" indicator on claims for all primary and all secondary diagnoses. If a condition is not present on admission, meaning that it was acquired during the inpatient stay, the New Mexico Medicaid program will not pay for any services or procedures involved in the treatment of that condition. For DRG cases, the DRG payable will exclude the diagnoses not present on admission for any Health-Care Acquired Conditions (HCAC). Claims will be paid as though the diagnosis code is not present.

3. **Other Provider Preventable Conditions (OPPC): All Healthcare Providers**
   The second category of PPCs is Other Provider Preventable Conditions (OPPCs), and applies to all Medicaid enrolled providers including physicians, inpatient and outpatient hospitals, ambulatory surgical centers, and other facilities. OPPCs are conditions occurring in any health care setting that could have reasonably been prevented through the application of evidence based guidelines. Providers are required to report on a claim if an OPPC occurs.

   If a provider reports any of the below diagnosis codes on a claim, the reduction in payment will be limited to the amounts directly identifiable as related to the PPC and the resulting treatment. OPPCs are defined as the following (condition with ICD code):
   - Performance of wrong operation (procedure) on correct patient;
   - Wrong device implanted into correct surgical site excludes: correct operation (procedure) performed on wrong body part;
   - Performance of operation (procedure) on patient not scheduled for surgery;
   - Performance of operation (procedure) intended for another patient;
   - Performance of operation (procedure) on wrong patient;
   - Performance of correct operation (procedure) on wrong side/body part;
   - Performance of correct operation (procedure) on wrong side; and
   - Performance of correct operation (procedure) on wrong site.

   Also, if a practitioner/provider reports any one of the below modifiers on a claim, the reduction in payment would be limited to the amounts directly identifiable as related to the OPPC and the resulting treatment.

- PA - Surgery, Wrong Body Part;
- PB - Surgery, Wrong Patient;
- PC – Wrong Surgery on Patient; and
- The New Mexico Medicaid program will continue to follow CMS guidelines and national coverage determinations (NCDs), including any future additions or changes to the current list of HAC conditions, diagnosis codes, and OPPCs.

Practitioners/providers may read more about the Provider Preventable Conditions policy on the CMS website at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and Reimbursement/Provider-Preventable-Conditions.html

Section 7 – Behavioral Health Medical Management Program – Level of Care Guidelines

A. Medical Necessity Definition

1. Medically necessary services are clinical and rehabilitative physical or behavioral health services that are:
    a. Essential to prevent, diagnose or treat medical conditions or are essential to enable an eligible recipient to attain, maintain or regain functional capacity;
    b. Delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical and behavioral health care needs of the eligible recipient;
    c. Provided within professionally accepted standards of practice and national guidelines; and
    d. Required to meet the physical and behavioral health needs of the eligible recipient and are not primarily for the convenience of the eligible recipient, the provider or the payer.

2. Application of the definition:
    a. A determination that a service is medically necessary does not mean that the service is a covered benefit or an amendment, modification or expansion of a covered benefit, such a determination will be made by the Medical Assistance Division (MAD) or its designee.
    b. The department or its authorized agent making the determination of the medical necessity of clinical, rehabilitative and supportive services consistent with the specific program's benefit package applicable to an eligible recipient will do so by:
        i. evaluating the eligible recipient's physical and behavioral health information provided by qualified professionals who have personally evaluated the eligible recipient within their scope of practice, who have taken into consideration the eligible recipient's clinical history including the impact of previous treatment and service interventions and who have consulted with other qualified health care professionals with applicable specialty training, as appropriate;
        ii. considering the views and choices of the eligible recipient or their personal representative regarding the proposed covered service as provided by the clinician or through independent verification of those views; and
        iii. considering the services being provided concurrently by other service delivery systems
    c. Physical and behavioral health services will not be denied solely because the eligible recipient has a poor prognosis. Required services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible recipient solely because of the diagnosis, type of illness or condition
    d. Decisions regarding MAD benefit coverage for eligible recipients under 21 years of age will be governed by the early periodic screening, diagnosis and treatment (EPSDT) coverage rules.
    e. Medically necessary service requirements apply to all medical assistance program rules.

B. Quality of Service Criteria

The following criteria are common to all levels of care for behavioral health conditions and substance use disorders. These criteria will be used in conjunction with criteria for specific level of care.

1. The member is eligible for benefits.
2. The provider completes a thorough initial evaluation, including current assessment information.
3. The member's condition and proposed services are covered under the terms of the benefit plan.
4. The member's current condition can be most efficiently and effectively treated in the proposed level of care.
5. The member's current condition cannot be effectively and safely treated in a lower level of care even when the treatment plan is modified, attempts to enhance the member's motivation have been made, or referrals to community resources or peer supports have been made.
6. There must be a reasonable expectation that essential and appropriate services will improve the member's presenting problems within a reasonable period of time. "Improvement" in this context is measured by weighing the effectiveness of treatment against the evidence that the member's condition will deteriorate if treatment is discontinued in the current level of care. Improvement must also be understood within the framework of the member's broader recovery goals.
7. The goal of treatment is to improve the member's presenting symptoms to the point that treatment in the current level of care is no longer required.
8. Treatment is not primarily for the purpose of providing respite for the family, increasing the member's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.
9. The member has provided informed consent to treatment. Informed consent includes the following:
    a. The member has been informed of safe and effective alternatives.
    b. The member understands the potential risks and benefits of treatment.
    c. The member is willing and able to follow the treatment plan including the safety precautions for treatment.
10. The treatment/service plan stems from the member's presenting condition, and clearly documents realistic and measurable treatment goals as well as the treatments that will be used to achieve the goals of treatment. The treatment/service plan also considers the following:
    a. Use of treatments that are consistent with nationally recognized scientific evidence, prevailing medical standards for the treatment of the member's current condition and clinical guidelines.
    b. Significant variables such as the member's age and level of development; the member's preferences, strengths, broader recovery goals and readiness for change; risks including barriers to care; past response to treatment; the member's understanding of his/her condition, its treatment and self-care; and the role that the member's family/social supports should play in treatment with the member's permission

c. Interventions needed to address co-occurring behavioral health or medical conditions.
d. Interventions that will promote the Member's participation in care, promote informed decision-making, and support the member's broader recovery goals. Examples of such interventions are psycho-education, motivational interviewing, recovery planning and use of an advance directive, as well as facilitating involvement with natural and cultural supports, and self-help or peer programs.
e. Involvement of the member's family/social supports in treatment and discharge planning with the member's permission when such involvement is clinically indicated.
f. How treatment will be coordinated with other behavioral health and medical providers as well as within the school system, legal system and community agencies with the member's permission.
g. How the treatment plan will be altered as the member's condition changes, or when the response to treatment is not as anticipated.

11. The discharge plan stems from the member's response to treatment, and considers the following:
    a. Significant variables including the member's preferences, strengths, broader recovery goals and readiness for change; risks including barriers to care; past response to discharge; the member's understanding of his/her condition, its treatment and self-care; and the role that the member's family/social supports should play in treatment with the member's permission.
    b. The availability of a lower level of care, which can effectively and safely treat the member's current clinical condition.
    c. The availability of treatments, which are consistent with nationally, recognized scientific evidence, prevailing medical standards for the treatment of the member's current condition and clinical guidelines.
    d. Involvement of the Member's family/social supports in discharge planning with the member's permission when such involvement is clinically indicated.
    e. How discharge will be coordinated with the provider of post-discharge behavioral health care, medical providers, as well as with the school system, legal system or community agencies with the member's permission.
12. How the risk of relapse will be mitigated including:
    a. Completing and accurate assessment of the member's current level of function and ability to follow through on the agreed upon discharge plan;
    b. Confirming that the member has engaged in shared decision making about the discharge plan and that the member understands and agrees with the discharge plan;
    c. Scheduling a first appointment within 7 days of discharge when care at a lower level is planned;
    d. Assisting the member with overcoming barriers to care (e.g. a lack of transportation or child care challenges);
    e. Ensuring that the member has an adequate supply of medication to bridge the time between discharge and the first scheduled follow-up psychiatric assessment;
    f. Providing psycho-education and motivational interviewing, assisting with recovery planning and use of an advance directive, and facilitating involvement with self-help and peer programs;

g. Confirming that the member understands what to do in the event that there is a crisis prior to the first post-discharge appointment, or if the member needs to resume services.

13. The availability of resources such natural and cultural supports, such as self-help and peer support programs, and peer-run services, which may augment treatment, facilitate the member's transition from the current level of care, and support the member's broader recovery goals.

C. Acute Inpatient Hospitalization

1. Definition of Service:

Acute Inpatient Psychiatric Hospitalization is a 24-hour secure and protected, medically staffed, psychiatrically supervised treatment service. This level of care is for stabilization of urgent or emergent behavioral health problems. Acute Inpatient Hospitalization is provided specifically for those members who, as a result of a psychiatric disorder, are an acute and significant danger to themselves or others, or are acutely and significantly disabled, or whose activities of daily living are significantly impaired. This level of care involves the highest level of skilled psychiatric services. It is rendered in a freestanding psychiatric hospital or the psychiatric unit of a general hospital. The care must be provided under the direction of an attending physician who performs a face-to-face interview of the member within 24 hours of admission. The care involves an individualized treatment plan that is reviewed and revised frequently based on the member's clinical status.

This level of care should not be authorized solely as a substitute for management within the adult corrections, juvenile justice or protective services systems, as an alternative to specialized schooling (which should be provided by the local school system), or simply to serve as respite or housing.

This level of care is available for all age ranges, but admission should be to a unit that is age appropriate. For school age children and youth, academic schooling funded through the local school system or by the facility is expected.

2. Admission Criteria (Meets A and B, and C or D or E or F or G):

a. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in 8.302.1.7 and the member has a DSM diagnosed condition that requires, and is likely to benefit from, the proposed therapeutic intervention.
b. Treatment cannot safely be administered in a less restrictive level of care.
c. There is an indication of actual or potential imminent danger to self that cannot be controlled outside of a 24-hour treatment setting. Examples of indications include serious suicidal ideation or attempts, severe self-mutilation or other serious self-destructive actions.
d. There is an indication of actual or potential imminent danger to others and the impulses to harm others cannot be controlled outside of a 24-hour treatment setting. An example of an indication includes a current threat and means to kill or injure someone.
e. There is an indication of actual or potential grave passive neglect that cannot be treated outside of an acute 24-hour treatment setting.

f. There is disordered or bizarre thinking, psychomotor agitation or retardation, and/or a loss of impulse control or impairment in judgment leading to behaviors that place the member or others in imminent danger. These behaviors cannot be controlled outside of a 24-hour treatment setting.
g. There is a co-existing medical illness that complicates the psychiatric illness or treatment. Together the illnesses or treatment pose a high risk of harm for the member, and cannot be managed outside of a 24-hour treatment setting.

3. Continued Stay Criteria (Meets All):

a. The member continues to meet admission criteria including the need for 24 hour medical supervision.
b. An individualized treatment plan that addresses the member's specific symptoms and behaviors that required Inpatient treatment has been developed, implemented and updated, with the member's and/or guardian's participation whenever possible, which includes consideration of all applicable and appropriate treatment modalities.
c. The member is making meaningful and measurable progress at the current level of care and/or the current or revised treatment plan can be reasonably expected to bring about significant improvements in the behaviors and/or symptoms leading to admission. Progress is documented toward treatment goals.
d. An individualized discharge plan has been developed which includes specific time-limited, realistic, objective and measurable discharge criteria and plans for appropriate follow-up care. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met.

4. Discharge Criteria (Meets All):

a. The member has met his/her individualized discharge criteria.
b. The member can be safely treated at a less intensive level of care.
c. An individualized discharge plan with appropriate, realistic and timely follow-up care has been formulated.

5. Exclusionary Criteria (May Meet Any):

a. The condition of primary clinical concern is one of a medical nature (not behavioral health) and, as outlined in the current Mixed Services Protocol, should be covered by another managed care entity.
b. The member appears to have presented for admission for reasons other than a primary psychiatric emergency, such as homelessness or in appropriate seeking of medications.

D. Waiting Placement Days (DAP) Rate

1. Description:

Per NMAC 8.321.2.16 Inpatient Days awaiting Placement (DAP) is a negotiated rate used when a Medicaid eligible member no longer meets acute care criteria and it is verified that the eligible member requires a residential level of care which may not be immediately located, those days during which the eligible member is awaiting placement to the lower level of care are termed "awaiting placement days." These circumstances must be beyond the control of the inpatient provider. **DAP is intended to be brief and to support transition to the lower level of care. DAP may not be used solely because the inpatient provider did not pursue or implement a discharge plan in a timely manner.**

2. Approval Criteria (Must Meet All):

a. The member is covered by Medicaid as administered by the Medical Assistance Division definition, and the member has a DSM diagnosed condition that has required an acute inpatient psychiatric level of care currently.
b. The member no longer meets continued stay criteria for inpatient acute psychiatric care and/or does meet discharge criteria and there is a specific discharge plan in place to a residential level of care, but documented barriers to implementation of that plan exist that are beyond the control of the provider or facility.
c. The provider has made reasonable efforts to identify and obtain the services needed to implement the discharge plan, and continues to actively work to identify resources to implement that plan.
d. The MCO has authorized the residential level of care sought as the discharge, and documentation of this authorization has been made available to MCO utilization management personnel.

3. Exclusionary Criteria:

a. The member has met his/her individualized discharge criteria and substantial barriers to discharge no longer exist.
b. The inpatient facility cannot demonstrate that it continues to actively work to eliminate barriers to the planned discharge.
c. The inpatient facility is pursuing a discharge to a level of care or service that a MCO psychiatrist peer reviewer has explicitly stated does not appear to meet admission criteria at this time.

E. 23 Hour Observation Stay

This is not a level of care that requires prior authorization but is a level of care that is separate and distinct from psychiatric inpatient level of care.

1. Definition of Service:

A 23 Hour Observation Stay occurs in a secure, medically staffed, psychiatrically supervised facility. This level of care, like acute inpatient hospitalization, involves the highest level of skilled psychiatric services. This service can be rendered in a psychiatric unit of a general hospital, or in the emergency department of a licensed hospital. The care must be provided under the direction of an attending physician who has performed a face-to-face evaluation of the member. The care involves an individual treatment plan that includes access to the full spectrum of psychiatric services. A 23 Hour Observation Stay provides an opportunity to evaluate members whose needed level of care is not readily apparent. In addition, it may be used to stabilize a member in crisis, when it is anticipated that the member's symptoms will resolve in less than 24 hours.

This level of care may be considered when support systems and/or a previously developed crisis plan have not sufficiently succeeded in stabilizing the member, and the likelihood for further deterioration is high. This level of care is available for all age ranges.

If a physician orders an eligible recipient to remain in the hospital for less than 24 hours, the stay is not covered as inpatient admission, but is classified as an observation stay. An observation stay is considered an outpatient service.

The following are exemptions to the general observation stay definition:

a. The eligible recipient dies;
b. Documentation in medical records indicates that the eligible recipient left against medical advice or was removed from the facility by his legal guardian against medical advice;
c. An eligible recipient is transferred to another facility to obtain necessary medical care unavailable at the transferring facility; or
d. An inpatient admission results in delivery of a child.

If an admission is considered an observation stay, the admitting hospital is notified that the services are not covered as an inpatient admission.

A hospital must bill these services as outpatient observation services.

Outpatient observation services must be medically necessary and must not involve premature discharge of an eligible recipient in an unstable medical condition.

The hospital or attending physician can request a re-review and reconsideration of the observation stay decision.

The observation stay review does not replace the review of one- and two-day stays for medical necessity.

Medically unnecessary admissions, regardless of length of stay, are not covered benefits.

2. Admission Criteria (Meets A and B, and C or D or E):

a. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in 8.302.1.7 and the member has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic intervention in less than 24 hours in a secure setting.
b. The member cannot be evaluated in a less restrictive level of care.
c. The member is expressing suicidal ideation or is expressing threats of harm to others that must be evaluated on a continuous basis for severity and lethality.
d. The member has acted in disruptive, dangerous or bizarre ways that require further immediate observation and assessment. An evaluation of the etiology of such behaviors is needed, especially if suspected to be chemically or organically induced.
e. The member presents with significant disturbances of emotions or thought processes that interfere with his/her judgment or behavior that could seriously endanger the member or others if not evaluated and stabilized on an emergency basis.

3. Discharge Criteria (Meets Both):

a. The member no longer meets admission criteria.
b. An individualized discharge plan with appropriate, realistic and timely follow-up care is in place.

4. **Exclusionary Criteria (May Meet Any):**
   a. The member meets admission criteria for Acute Inpatient Hospitalization.
   b. The member appears to have presented for admission for reasons other than a primary psychiatric emergency, such as homelessness or in appropriate seeking of medications

F. Accredited Residential Treatment

1. **Definition of Service:**

Accredited Residential Treatment Center Services (ARTC) is a service provided to members under the age of 21 whom, because of the severity or complexity of their behavioral health needs. These are members who, as a result of a recognized psychiatric disorder(s) are a significant danger to themselves or others. ARTC facilities must be licensed by the New Mexico Department of Children Youth & Family, Licensing and Credentialing Authority (or similar body when located in other states). The need for ARTC services must be identified in the tot to teen Healthcheck or other diagnostic evaluation furnished through a Healthcheck referral and the member must meet medical necessity criteria as part of early and periodic screening, diagnosis and treatment (EPSDT) services [42 CFR Section 441.57].

ARTC services are provided in a 24-hour a day/ 7 days a week accredited (The Joint Commission, http://www.jointcommission.org/) facility. Facilities provide all diagnostic and therapeutic services provided. ARTC units are medically staffed at all times with direct psychiatric services provided several days a week and with 24-hour psychiatric consultation availability. The services are provided under the direction of an attending psychiatrist. The treatment plan is reviewed frequently and updated based on member's clinical status. Regular family therapy is a key element of treatment and is required except when clinically contraindicated. Discharge planning should begin at admission, including plans for successful reintegration into the home, school and community. If discharge to a home/family may not be a realistic option, alternative placement/housing must be identified as soon as possible and documentation of active efforts to secure such placement must be thorough.

This service should not be authorized solely as a substitute for management within the juvenile justice or protective services systems, as an alternative to specialized schooling (which should be provided by the local school system) or simply to serve as respite or housing. Academic schooling funded through the local school system or by the facility is expected.

As discussed in NMAC 8.321.2.11 in addition to regularly scheduled structured counseling and therapy sessions (individual, group, family, or multifamily - based on individualized needs, and as specified in the treatment plan), ARTC also includes facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance and money management. ARTC also includes therapeutic services to meet the physical, social, cultural, recreational, health maintenance and rehabilitation needs of recipients that are not primarily recreational or diversional in nature. Also, ARTC will not implement experimental or investigational procedures, technologies, or non-drug therapies or related services.

2. **Admission Criteria (Meets All):**
    a. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in NMAC 8.302.1.7 and the member has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic intervention.
    b. The member is experiencing emotional or behavioral problems in the home and/or community to such an extent that the safety or well-being of the member or others is substantially at risk. These problems require a supervised, structured, and 24-hour continuous therapeutic milieu. A licensed behavioral health professional has made the assessment that the member is likely to experience a deterioration of his/her condition to the point that inpatient hospitalization may be required if the individual is not treated at this level of care.
    c. Less restrictive or intensive levels of treatment have been tried and shown to be inadequate to meet the member's needs. Documentation exists to support these contentions.

3. **Continued Stay Criteria (Meets All):**
    a. The member continues to meet admission criteria including the need for 24 hour staff supervision
    b. The current or revised treatment plan can be reasonable expected to bring about significant improvements or progress to address the goals of treatment. Progress is documented toward treatment goals.
    c. The treatment and therapeutic goals are objective, measurable and time-limited to address the alleviation of psychiatric symptoms and precipitating psychosocial stressors.
    d. An individualized discharge plan has been developed/updated which includes specific realistic, objective and measurable discharge criteria and plans for appropriate follow-up care within the member's community. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met.
    e. An individualized discharge plan has been developed/ updated which includes specific realistic, objective and measurable discharge criteria and plans for appropriate follow-up care within the member's community. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met.
    f. The member is actively participating in treatment, and is motivated and engaged in are active that lead to the member's discharge plan.
    g. The member's parent(s), guardian or custodian is participating in the treatment and discharge planning,. If parent (s), guardian or custodian are not involved, alternative natural supports need to be identified to engage in treatment and discharge planning
    h. Member is making progress in the treatment program. Goals are realistic, targeted, time-limited, and achievable.

4. **Discharge Criteria (Meets All):**
    a. The member has met his/her individualized discharge criteria.
    b. The member can be safely treated at a less intensive/restrictive level of care.
    c. An individualized discharge plan with linkage to appropriate, realistic and timely follow-up care is in place.

5. **Exclusionary Criteria For ARTC: (May Meet Any)**
   a. There is evidence (documented) that the ARTC placement is intended as an alternative to incarceration or community corrections involvement, and medical necessity have not been met.
   b. There is evidence that the ARTC treatment episode is intended to defer or prolong a permanency plan determination. The inability of unwillingness of a parent or guardian to receive the member back into the home is not grounds for continued ARTC care.
   c. The individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.
   d. Quality of Service Criteria # 5 has not been met: *The member's current condition cannot be effectively and safely treated in a lower level of care even when the treatment plan is modified, attempts to enhance the member's motivation have been made, or referrals to community resources or peer supports have been made.*
   e. Quality of Service Criteria # 8 has not been met: *Treatment is not primarily for the purpose of providing respite for the family, increasing the member's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.*

G. Sub-Acute Residential Treatment

Not a Value Added Service, and is only available to providers contracted specifically to provide this service.

1. **Definition of Service:**

Sub Acute RTC is provided to members under the age of 21 who, because of the severity or complexity of their behavioral health needs, and who require services beyond the scope of the usual Residential Treatment Center Services (RTC) milieu or other out-of-home or community-based treatment services. These are members who, as a result of a recognized psychiatric disorder(s) are a significant danger to themselves or others, but not so acute as to be in need of inpatient hospitalization. Sub Acute RTC facilities must be licensed by the New Mexico Department of Children Youth & Family, Licensing and Credentialing Authority (or similar body when located in other states). The need for RTC services must be identified in the tot to teen Healthcheck or other diagnostic evaluation furnished through a Healthcheck referral and the member must meet medical necessity criteria as part of early and periodic screening, diagnosis and treatment (EPSDT) services [42 CFR Section 441.57].

Sub Acute RTC services are provided in a 24-hour a day/ 7 days a week accredited (The Joint Commission, http://www.jointcommission.org/) facility. Facilities provide all the diagnostic and therapeutic services provided by an RTC, **but with a higher staff to client ratio**. Sub Acute RTC units are medically staffed at all times with direct psychiatric services provided several days a week and with 24-hour psychiatric consultation availability. The services are provided under the direction of an attending psychiatrist. The treatment plan is reviewed frequently and updated based on member's clinical status. Regular family therapy is a key element of treatment and is required except when clinically contraindicated. Discharge planning should begin at admission, including plans for successful reintegration into the home, school and community. If discharge to a home/family may not be a realistic option, alternative placement/housing must be

identified as soon as possible and documentation of active efforts to secure such placement must be thorough.

This service should not be authorized solely as a substitute for management within the juvenile justice or protective services systems, as an alternative to specialized schooling (which should be provided by the local school system) or simply to serve as respite or housing. Academic schooling funded through the local school system or by the facility is expected.

As discussed in NMAC 8.321.2.11 in addition to regularly scheduled structured counseling and therapy sessions (individual, group, family, or multifamily - based on individualized needs, and as specified in the treatment plan), Sub Acute RTC also includes facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance and money management. Sub Acute RTC also includes therapeutic services to meet the physical, social, cultural, recreational, health maintenance and rehabilitation needs of recipients that are not primarily recreational or diversional in nature. Also, Sub Acute RTC will not implement experimental or investigational procedures, technologies, or non-drug therapies or related services.

2. Admission Criteria (Meets All):

a. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in NMAC 8.302.1.7 and the member has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic intervention.
b. The member is experiencing emotional or behavioral problems in the home and/or community to such an extent that the safety or well-being of the member or others is substantially at risk. These problems require a supervised, structured, and 24-hour continuous therapeutic milieu. A licensed behavioral health professional has made the assessment that the member is likely to experience a deterioration of his/her condition to the point that inpatient hospitalization may be required if the individual is not treated at this level of care.
c. Less restrictive or intensive levels of treatment have been tried and shown to be inadequate to meet the member's needs. Documentation exists to support these contentions.

3. Continued Stay Criteria (Meets All):

a. The member continues to meet admission criteria including 24 hour staff supervision
b. An individualized treatment plan that addresses the member's specific symptoms and behaviors that required Sub Acute RTC treatment has been developed, implemented and updated, with the member's or guardian's participation whenever possible, which includes consideration of all applicable and appropriate treatment modalities The treatment and therapeutic goals are objective, measurable and time-limited.
c. The current or revised treatment plan can be reasonable expected to bring about significant improvements or progress to address the goals of treatment. Progress is documented toward treatment goals.
d. An individualized discharge plan has been developed/ updated which includes specific realistic, objective and measurable discharge criteria and plans for appropriate follow-

up care. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met.

e. The member is participating in treatment, or there are active efforts being made that can reasonably be expected to lead to the member's engagement in treatment.

The member's parent(s), guardian or custodian is participating in the treatment and discharge planning, or persistent efforts are being made and documented to involve them, unless it is clinically contraindicated.

4. Discharge Criteria (Meets A or B, and C and D):

a. The member has met his/her individualized discharge criteria.
b. The member has not benefited from Sub Acute Residential Treatment Center
c. Services despite documented persistent efforts to engage the member.
d. The member can be safely treated at a less intensive/restrictive level of care.

An individualized discharge plan with linkage to appropriate, realistic and timely follow-up care is in place.

5. Exclusionary Criteria For Sub-Acute RTC: (May Meet Any):

a. There is evidence (documented) that the Sub Acute RTC placement is intended as an alternative to incarceration or community corrections involvement, and medical necessity have not been met. There is evidence that the Sub Acute RTC treatment episode is intended to defer or prolong a permanency plan determination. The inability of unwillingness of a parent or guardian to receive the member back into the home is not grounds for continued Sub Acute RTC care.
b. The individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.
c. The member's current condition cannot be effectively and safely treated in a lower level of care even when the treatment plan is modified, attempts to enhance the member's motivation have been made, or referrals to community resources or peer supports have been made.
d. Treatment is not primarily for the purpose of providing respite for the family, increasing the member's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.

H. Residential Treatment Center Services

1. Definition of Service:

Residential Treatment Center Services (RTC), as governed by NMAC 8.321.2.20 (non-accredited RTC) are provided to members under the age of 21 years who require 24-hour treatment and supervision in a safe therapeutic environment.

Non-Accredited Residential Treatment Centers and Group Homes:

The New Mexico Medicaid program (Medicaid) pays for medically necessary health services furnished to eligible recipients. To help New Mexico recipients under twenty-one (21) years of age who need the level of care furnished by psychosocial rehabilitation services in a residential setting, the New Mexico Medical Assistance Division (MAD) pays for services furnished in non-accredited residential treatment centers or group homes as

part of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services [42 CFR § 441.57]. The need for non-accredited residential treatment center and group home services must be identified in the Tot to Teen Healthcheck screen or other diagnostic evaluation furnished through a Healthcheck referral. This section describes eligible providers, covered services, service limitations, and general reimbursement methodology.

Provider Responsibilities

Providers who furnish services to Medicaid recipients must comply with all specified Medicaid participation requirements. See Section MAD-701(8.302.1), GENERAL PROVIDER POLICIES. Providers must verify that individuals are eligible for Medicaid at the time services are furnished and determine if Medicaid recipients have other health insurance.

Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See Section MAD-701(8.302.1), GENERAL PROVIDER POLICIES. Providers must maintain records documenting the source and amount of nay financial resource collected or receive by provider by behalf of recipients, including federal or state governmental sources and document receipt and disbursement of recipient funds.

Covered Services

Medicaid covers those medically necessary services for recipients under twenty-one (21) years of age which are designed to develop skills necessary for successful reintegration into the family or transition into the community. A level of care determination must indicate that the recipient needs the level of care that is furnished in non-accredited residential treatment centers or group homes. Residential services must be rehabilitative and provide access to necessary treatment services in a therapeutic environment.

The following services must be furnished by centers to receive reimbursement from Medicaid. Payment for performance of these services is included in the center's reimbursement rate:

a. Performance of necessary evaluations and psychological testing for development of the treatment plan, while ensuring that evaluations already performed are not repeated;
b. Regularly scheduled structured counseling and therapy sessions for recipients, groups, families, or multifamily groups based on individualized needs, as specified in the treatment plan;
c. Facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance, and money management;
d. Assistance to recipients in self-administration of medication in compliance with state policies and procedures;
e. Appropriate staff available on a twenty-four (24) hour basis to respond to crisis situations, determine the severity of the situation, stabilize recipients by providing support, make referrals, as necessary, and provide follow-up;
f. Consultation with other professionals or allied care givers regarding a specific recipient;
g. Non-medical transportation services needed to accomplish the treatment objective; and

h. Therapeutic services to meet the physical, social, cultural, recreational, health maintenance, and rehabilitation needs of recipients.

Non-covered Services

Services furnished by non-accredited treatment centers or group homes are subject to the limitations and coverage restrictions which exist for other Medicaid services. See Section MAD-602, GENERAL NONCOVERED SERVICES. Medicaid does not cover the following specific activities furnished in non-accredited residential treatment centers or group homes:

a. Services not considered medically necessary for the condition of the recipients, as determined by MAD or its designee;
b. Room and board;
c. Services for which prior approval was not obtained;
d. Services furnished after the determination is made by MAD or its designee that the recipient no longer needs care
e. Formal educational or vocational services related to traditional academic subjects or vocational training;
f. Experimental or investigations procedures, technologies, or non-drug therapies and related services;
g. Drugs classified as "ineffective" by FDA Drug Evaluations; and
h. Activity therapy, group activities, and other services which are primarily recreational or diversional in nature.

Treatment Plan

An individualized treatment plan used in non-accredited residential treatment centers or group homes must be developed by a team of professionals in consultation with recipients, parents, legal guardians or others in whose care recipients will be released after discharge.

The plan must be developed within fourteen (14) days of the recipient's admission.

a. The interdisciplinary team must review the treatment plan at least every thirty (30) days.
b. The following must be contained in the treatment plan or documents used in the development of the treatment plan. The treatment plan and all supporting documentation must be available for review in the recipient's file:
    i. Statement of the nature of the specific problem and the specific needs of the recipient;
    ii. Description of the functional level of the recipient, including the following:
        - Mental status assessment;
        - Intellectual function assessment;
        - Psychological assessment;
        - Educational assessment;
        - Vocational assessment;
        - Social assessment;
        - Medication assessment; and
        - Physical assessment.
    iii. Statement of the least restrictive conditions necessary to achieve the purposes of treatment;

iv. Description of intermediate and long-range goals, with the projected timetable for their attainment and the duration and scope of therapy services;
v. Statement and rationale of the plan of treatment for achieving these intermediate and long-range goals, which includes provisions for review and modification of the plan;
vi. Specification of staff responsibilities, description of proposed staff involvement, and orders for medication(s), treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the recipient; and
vii. Criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge, and projected date of discharge.

2. Admission Criteria (Meets All):

a. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in NMAC 8.305.1, and the member has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic intervention.
b. The member is experiencing emotional or behavioral problems in the home, community and/or treatment setting to such an extent that the safety or well-being of the member or others is at risk. These problems require a supervised, structured, and 24-hour continuous therapeutic milieu in a residential setting.
c. A licensed behavioral health professional has made the assessment that the member is likely to experience a deterioration of his/her condition to the point that a more restrictive treatment setting may be required if the individual is not treated at this level of care at this time.
d. Less restrictive or intensive levels of treatment have been tried and shown to be inadequate to meet the member's needs. Documentation exists to support these contentions.

3. Continued Stay Criteria (Meets All):

a. The member continues to meet admission criteria including the need for 24 hour staff supervision.
b. An individualized treatment plan that addresses the member's specific symptoms and behaviors that required Residential treatment has been developed, implemented and updated, with the member's or guardian's participation, which includes consideration of all applicable and appropriate treatment modalities. The treatment and therapeutic goals are objective, measurable and time-limited
c. The current or revised treatment plan can be reasonable expected to bring about significant improvements or progress to address the goals of treatment. Progress is documented toward treatment goals.
d. An individualized discharge plan has been developed which includes specific realistic, objective and measurable discharge criteria and plans for appropriate follow-up care within the member's community. A timeline for expected implementation and completion is in place but discharge criteria have not yet been, or other barriers to discharge exist which the provider has made reasonable efforts to mitigate.
e. The member is actively participating in treatment and is motivated and engaged in active efforts to lead to the Member's discharge plan.

f. The member's parent(s), guardian or/or custodian is participating in treatment and discharge planning. If parent(s), guardian or custodian care are not involved, alternative natural supports need to be identified to engage in treatment and discharge planning. Criteria for this is weekly involvement in family therapy, treatment planning and discharge planning
g. Member is making progress in the treatment program. Goals are realistic, targeted, time-limited, and achievable.

4. Discharge Criteria (Meets A or B, and C and D):

a. The member has met his/her individualized discharge criteria.
b. The member has not realized substantial benefit from Residential Treatment Services despite documented persistent efforts to engage the member.
c. The member can be safely treated at a less intensive/restrictive level of care.

d. An individualized discharge plan with linkage to appropriate, realistic and timely follow-up care is in place.

5. Exclusionary Criteria for RTC: (May Meet Any):

a. There is evidence that the RTC placement is intended as an alternative to incarceration or community corrections involvement, and medical necessity have not been met.
b. There is evidence that the RTC treatment episode is intended to defer or prolong a permanency plan determination. The inability or unwillingness of a parent or guardian to receive the member back into the home is not grounds for continued RTC care.
c. The individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.
d. The member's current condition cannot be effectively and safely treated in a lower level of care even when the treatment plan is modified, attempts to enhance the member's motivation have been made, or referrals to community resources or peer supports have been made.
e. Treatment is not primarily for the purpose of providing respite for the family, increasing the member's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.

I. Treatment Foster Care I and II

1. Definition of Service:

Treatment Foster Care (TFC), as governed by NMAC 8.321.2.25 and NMAC 8.321.2.26 is a behavioral health service provided to members under the age of 21 years who are placed in a 24-hour community-based supervised, trained, surrogate family through a TFC placement agency licensed by the New Mexico Department of Children Youth & Family, Licensing and Credentialing Authority.

NMAC citation 8.322.2/ MAD citation 745.1 TREATMENT FOSTER CARE Level I and Level II: The New Mexico Medicaid program (Medicaid) pays for medically necessary health services furnished to eligible recipients. The New Mexico Medical Assistance Division (MAD) pays for mental health services furnished to recipients under twenty-one (21) years of age who have an identified need for treatment foster care and meet this level of care as part of Early and Periodic Screening, Diagnosis and Treatment

(EPSDT) services [42 CFR § 441.57]. The need for treatment foster care services must be identified in the Tot to Teen HealthCheck or other diagnostic evaluation furnished through a HealthCheck referral. This section describes eligible providers, covered services, service limitations, and general reimbursement methodology.

Provider Responsibilities Providers who furnish services to Medicaid recipients must comply with all specified Medicaid participation requirements. See Section MAD-701, GENERAL PROVIDER POLICIES. Providers must verify that individuals are eligible for Medicaid at the time services are furnished and determine if Medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services provided to recipients. See Section MAD-701, GENERAL PROVIDER POLICIES. Providers must maintain records documenting the source and amount of any financial resource collected or receive by provider by behalf of recipients, including federal or state governmental sources and document receipt and disbursement of recipient funds.

Covered Services
Medicaid covers those services included in individualized treatment plans which are designed to help recipients develop skills necessary for successful reintegration into the natural family or transition into the community.

a. The family living experience is the core treatment service to which other individualized services can be added. Treatment foster parents are employed or contracted by the treatment foster care agency. Their responsibilities include:
    i. Participation in the development of treatment plans for recipients by providing input based on their observations;
    ii. Assumption of primary responsibility for implementing the in-home treatment strategies specified in a treatment plan;
    iii. Recording information and documentation of activities, as required by the foster care agency and the standards under which it operates;
    iv. Helping recipients maintain contact with their families and enhancement of those relationships;
    v. Supporting efforts specified by the treatment plan to meet the recipient's permanency planning goals; and
    vi. Assisting recipients obtain medical, educational, vocational, and other services to reach goals identified in treatment plans.
b. The following services must be furnished by the agency certified for treatment foster care to receive reimbursement from Medicaid. Payment for performance of these services is included in the provider's reimbursement rate:
    i. Assessment of the recipient's progress in TFC and assessment of family interactions and stress;
    ii. Regularly scheduled counseling and therapy sessions for recipients in individual, family, or group sessions;
    iii. Facilitation of age-appropriate skill development in the areas of household management, nutrition, physical and emotional health, basic life skills, time management, school attendance, money management, independent living, relaxation techniques, and self-care techniques;
    iv. Crisis intervention, including twenty-four (24) hour availability of appropriate

staff to respond to crisis situations; and

v. When a return to the natural family is planned, assessment of family strengths and needs and development of a family service plan.

Non-covered Services

Treatment foster care services are subject to the limitations and coverage restrictions which exist for other Medicaid services. See Section MAD-602, GENERAL NON-COVERED SERVICES. Medicaid does not cover the following services:

a. Room and Board;
b. Formal educational or vocational services related to traditional academic subjects or vocational training; and
c. Respite care.

Treatment Plan

The treatment plan must be developed by the treatment team in consultation with recipients, families or legal guardians, physicians, if applicable, and others in whose care recipients will be released after discharge. The plan must be developed within fourteen (14) days of a recipient's admission to the TFC program.

a. The treatment team must review the treatment plan every thirty (30) days.
b. The following must be contained in the treatment plan or documents used in the development of the treatment plan. The treatment plan and all supporting documentation must be available for review in the recipient's file:

i. Statement of the nature of the specific problem and the specific needs of the recipient;
ii. Description of the functional level of the recipient, including the following:
- Mental status assessment;
- Intellectual function assessment;
- Psychological assessment;
- Educational assessment;
- Vocational assessment;
- Social assessment;
- Medication assessment; and
- Physical assessment.

iii. Statement of the least restrictive conditions necessary to achieve the purposes of treatment;
iv. Description of intermediate and long-range goals, with the projected timetable for their attainment and the duration and scope of therapy services;
v. Statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including provisions for review and modification of the plan;
vi. Specification of staff and TFC parent responsibilities, description of proposed staff involvement, orders for medication(s), treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the recipient; and

vii. Criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge, and projected date of discharge.

NMAC citation 322.5/ MAD citation 745.5 TREATMENT FOSTER CARE (LEVEL II): The New Mexico Medicaid program (Medicaid) pays for medically necessary health services furnished to eligible recipients. The New Mexico Medical Assistance Division (MAD) pays for mental health services furnished to recipients under twenty-one (21) years of age who have an identified need for treatment foster care and meet this level of care as part of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services [42 CFR § 441.57]. The need for treatment foster care services must be identified in the Tot to Teen HealthCheck or other diagnostic evaluation furnished through a HealthCheck referral. This section describes eligible providers, covered services, service limitations, and general reimbursement methodology. [11-1-99]

Provider Responsibilities

Providers who furnish services to Medicaid recipients must comply with all specified Medicaid participation requirements. See Section MAD-701 (8.302.1), GENERAL PROVIDER POLICIES. Providers must verify that individuals are eligible for Medicaid at the time services are furnished and determine if Medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services provided to recipients. See Section MAD-701 (8.302.1), GENERAL PROVIDER POLICIES. Providers must maintain records documenting the source and amount of any financial resource collected or received by the provider on behalf of recipients, including federal or state governmental sources and document receipt and disbursement of recipient funds. [11-1-99]

Covered Services

Treatment Foster Care II is a mental and behavioral health treatment modality provided by a specially trained treatment foster care parent or family in his or her or their home. Treatment parents are employed by or contracted for and trained by a TFC agency certified by The New Mexico Children, Youth and Families Department (CYFD). TFC II combines the normalizing influence of family-based care with individualized treatment interventions and social supports, thereby creating a therapeutic environment in the family context or maintaining and extending an existing therapeutic context established in TFC. Through the provision of TFC II services, the child's symptoms are expected to decrease and functional level to improve or maintain so that he or she may be discharged successfully to a less restrictive setting, that best meets the child's needs. Medicaid covers those services included in the individualized treatment plan which are designed to help recipients develop skills necessary for successful reintegration into the biological, foster or adoptive family or transition to the community. TFC II will allow for a step-down from TFC when the child improves and no longer meets those utilization review criteria. TFC II will also allow entry into the program at a lower level of care for those children who would benefit optimally from the treatment foster care model.

a. The therapeutic family living experience is the core treatment service to which other individualized services can be added. Treatment foster parents are employed or contracted by the treatment foster care agency. Their responsibilities include:

i. Participation in the development of treatment plans for recipients by providing input based on their observations;
ii. Assumption of primary responsibility for implementing the in-home treatment strategies as specified in an individualized treatment plan;
iii. Recording of information and documentation of all activities required by the foster care agency and the standards under which it operates;
iv. Helping recipients maintain contact with their families and fostering enhancement of those relationships as appropriate;
v. Supporting efforts specified by the treatment plan to meet the recipient's permanency planning goals; and
vi. Through coordinating, linking and monitoring services, assist recipients to obtain medical, educational, vocational, and other necessary services to reach goals identified in the treatment plan.

b. The following services must be performed by the agency or be contracted for and overseen by the agency certified for treatment foster care to receive reimbursement from Medicaid.
i. Assessment of the recipient and his biological, foster or adoptive family's strengths and needs;
ii. Development of a discharge plan that includes a strengths and needs assessment of the recipient's family when a return to that family is planned, including a family service plan;
iii. Development and monitoring of the treatment plan;
iv. Assessment of the recipient's progress in TFC II;
v. Assessment of the TFC II family's interaction with the recipient, his or her biological, foster or adoptive family, and any stressors identified;
vi. Facilitation of age-appropriate skills development in the areas of household management, nutrition, physical, behavioral and emotional health, basic life skills, social skills, time management, school and/or work attendance, money management, independent living skills, relaxation techniques, and self-care techniques;
vii. Ensuring the occurrence of counseling or therapy sessions for recipients in individual, family and/or group sessions as specified in the treatment plan; and
viii. Ensuring the availability of crisis intervention, including twenty-four (24) hour a day, seven (7) days a week) availability of appropriately licensed parties to respond to crisis situations. [11-1-99]

Non-covered Services

Treatment foster care services are subject to the limitations and coverage restrictions which exist for other Medicaid services. See Section MAD-602, GENERAL NONCOVERED SERVICES. Medicaid does not cover the following services:

a. Room and Board;
b. Formal educational or vocational services related to traditional academic subjects or vocational training; and
c. Respite care. [11-1-99]

Treatment Plan

The treatment plan must be developed by the treatment team in consultation with the recipient, his or her biological, foster or adoptive family or legal guardian, physician(s),

when applicable, and others in whose care the recipient is involved and/or in whose care to whom the recipient will be released after discharge. The plan must be developed within fourteen (14) days of a recipient's admission to the TFC II program.

a. The treatment coordinator must review the treatment plan every thirty (30) days.
b. The following must be contained in the treatment plan or documents used in the development of the treatment plan. The treatment plan and all supporting documentation must be available for review in the recipient's file:
    i. Statement of the nature of the specific problem and the specific needs and strengths of the recipient;
    ii. Description of the functional level of the recipient, including the following:
        - Mental status assessment;
        - Intellectual function assessment;
        - Psychological assessment;
        - Educational assessment;
        - Vocational assessment;
        - Social assessment;
        - Medication assessment; and
        - Physical assessment.
    iii. Statement of the least restrictive conditions necessary to achieve the purposes of treatment;
    iv. Description of intermediate and long-range goals with the projected timetable for their attainment;
    v. Statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including provisions for review and modification of the plan;
    vi. Specification of staff and TFC II parent responsibilities and the description and frequency of the following components: proposed staff involvement, orders for medication(s), treatments, restorative and rehabilitative services, activities, therapies, social services, special diet, and special procedures recommended for the health and safety of the recipient; and
    vii. Criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge, and projected date of discharge. [11-1-99]

2. Admission Criteria (Meets A, B, E, and C or D):

**These admission criteria are for both TFC I and II, with some caveats, as noted below.*

a. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in NMAC 8.305.1, and the member has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic interventions implemented in a TFC/ family living experience treatment setting.
b. The member's current (within 30 days of proposed admission) medical and psychiatric symptoms require and can be managed safely in a 24-hour supervised community/home-based setting.
c. The member is immediately at risk for needing a higher level of services and/or being excluded from community, home or school activities due to clinically significant disruptive symptoms or behaviors. These symptoms or behaviors are not amenable to treatment in the member's own home or a standard foster care environment.
d. A licensed behavioral health professional has made the assessment that the member is likely to experience a deterioration of his/her condition to the point that a more

restrictive treatment setting may be required if the individual is not treated at this level of care at this time.

e. Less restrictive or intensive levels of treatment have been tried and shown to be inadequate to meet the member's needs. Documentation exists to support these contentions.

For <u>TFC I</u> the following additional admission criteria must be met:
The member is unable to participate independently (without 24-hour adult supervision) in age appropriate activities.

For <u>TFC II</u> the following additional admission criteria must be met:
The member has met the treatment goals of TFC I or is able to participate independently in age appropriate activities without 24-hour adult supervision.

Additionally, to be appropriate for TFC II, the member's treatment needs or social, behavioral, emotional, or functional impairments are not as serious or severe as those exhibited by members who meet criteria for TFC I; therefore services are less clinically intensive than those provided in TFC I. Members in TFC II can generally participate independently in age appropriate activities (e.g. dressing self at age 7, working at age 16, attending school without parental classroom supervision), while members in TFC I could require supervision for those activities. TFC II is often, but not always, used as a transition from TFC I; members may be admitted directly to TFC II. Conversely, <u>not all members in TFC I need to go to TFC II before discharge from TFC.</u>

3. Continued Stay Criteria (Meets All):

a. The member continues to meet all relevant admission criteria.
b. The member continues to need 24-hour adult supervision and/or assistance to develop, restore or maintain skills and behaviors that are necessary to live safely in their own home and community.
c. An individualized treatment plan that addresses the member's specific symptoms and behaviors that required TFC treatment has been developed, implemented and updated according to licensing rules, with the member's and/or legal guardian's participation, which includes consideration of all applicable and appropriate treatment modalities. The treatment and therapeutic goals are objective, measurable and time-limited.
d. The current or revised treatment plan can be reasonable expected to bring about significant improvements or progress to address the goals of treatment. Progress is documented toward treatment goals.
e. An individualized discharge plan has been developed (and updated since the last clinical review/approval) which includes specific realistic, objective and measurable discharge criteria and plans for appropriate follow-up care. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met.
f. The member is participating in treatment, or there are active, persistent efforts being made that can reasonably be expected to lead to the member's engagement in treatment.
g. The parent, legal guardian or custodian is participating in the treatment, discharge and/or permanency planning, or persistent efforts are being made and documented to involve them, unless it is clinically indicated otherwise.

4. **Criteria for Transition From TFC I to TFC II (Meets All):**
   a. A review of the individualized treatment and permanency plan shows that the member has met a significant portion of all TFC I treatment goals.
   b. Continued stay in a treatment foster care setting is necessary to maintain the gains made in TFC I, but member does not require the intensity of supervision associated with TFC I.
   c. The member is able to participate independently in age appropriate activities without continuous adult supervision.

5. **Discharge Criteria (Meets A or B, and C and D):**
   a. The member has met his/her individualized discharge criteria.
   b. The member has not benefited from Treatment Foster Care despite documented persistent efforts to engage the member.
   c. The member can be safely treated at a less intensive level of care.
   d. An individualized discharge plan with appropriate, realistic and timely follow-up care is in place.

6. **Exclusionary Criteria for TFC I AND TFC II (May Meet Any):**
   a. There is evidence that the TFC placement is intended as an alternative to incarceration or community corrections involvement, and medical necessity have not been met.
   b. There is evidence that the TFC treatment episode is intended to defer or prolong a permanency plan determination, or is substituting for permanent housing.
   c. The individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.
   d. Quality of Service Criteria: The member's current condition cannot be effectively and safely treated in a lower level of care even when the treatment plan is modified, attempts to enhance the member's motivation have been made, or referrals to community resources or peer supports have been made.
   e. Quality of Service Criteria Treatment is not primarily for the purpose of providing respite for the family, increasing the member's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.

J. Group Home

1. **Definition of Service:**

   Group Home is a lower level of care than Residential Treatment Center Services and is indicated when a structured home-based living situation is unavailable or not clinically appropriate for the member's behavioral health needs and the member needs services focused on psychosocial skills development. Group Home services also differ from Treatment Foster Care in that they are residentially and group based, rather than family and community based.

   NMAC citation 321.4 /MAD citation 742.3 NON-ACCREDITED RESIDENTIAL TREATMENT CENTERS AND GROUP HOMES:

   The New Mexico Medicaid program (Medicaid) pays for medically necessary health services furnished to eligible recipients. To help New Mexico recipients under twenty-one (21) years of age who need the level of care furnished by psychosocial rehabilitation

services in a residential setting, the New Mexico Medical Assistance Division (MAD) pays for services furnished in non-accredited residential treatment centers or group homes as part of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services [42 CFR § 441.57]. The need for non-accredited residential treatment center and group home services must be identified in the Tot to Teen HealthCheck screen or other diagnostic evaluation furnished through a HealthCheck referral. This section describes eligible providers, covered services, service limitations, and general reimbursement methodology.

Provider Responsibilities

Providers who furnish services to Medicaid recipients must comply with all specified Medicaid participation requirements. See Section MAD-701, GENERAL PROVIDER POLICIES. Providers must verify that individuals are eligible for Medicaid at the time services are furnished and determine if Medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See Section MAD-701, GENERAL PROVIDER POLICIES. Providers must maintain records documenting the source and amount of nay financial resource collected or receive by provider by behalf of recipients, including federal or state governmental sources and document receipt and disbursement of recipient funds.

Covered Services

Medicaid covers those medically necessary services for recipients under twenty-one (21) years of age which are designed to develop skills necessary for successful reintegration into the family or transition into the community. A level of care determination must indicate that the recipient needs the level of care that is furnished in non-accredited residential treatment centers or group homes. Residential services must be rehabilitative and provide access to necessary treatment services in a therapeutic environment. The following services must be furnished by centers to receive reimbursement from Medicaid. Payment for performance of these services is included in the center's reimbursement rate:

a. Performance of necessary evaluations and psychological testing for development of the treatment plan, while ensuring that evaluations already performed are not repeated;
b. Regularly scheduled structured counseling and therapy sessions for recipients, groups, families, or multifamily groups based on individualized needs, as specified in the treatment plan;
c. Facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance, and money management;
d. Assistance to recipients in self-administration of medication in compliance with state policies and procedures;
e. Appropriate staff available on a twenty-four (24) hour basis to respond to crisis situations, determine the severity of the situation, stabilize recipients by providing support, make referrals, as necessary, and provide follow-up;
f. Consultation with other professionals or allied care givers regarding a specific recipient;
g. Non-medical transportation services needed to accomplish the treatment objective; and
h. Therapeutic services to meet the physical, social, cultural, recreational, health maintenance, and rehabilitation needs of recipients.

Non-covered Services

Services furnished by non-accredited treatment centers or group homes are subject to the limitations and coverage restrictions which exist for other Medicaid services. See Section MAD-602, GENERAL NONCOVERED SERVICES. Medicaid does not cover the following specific activities furnished in non-accredited residential treatment centers or group homes:

a. Services not considered medically necessary for the condition of the recipients, as determined by MAD or its designee;
b. Room and board;
c. Services for which prior approval was not obtained;
d. Services furnished after the determination is made by MAD or its designee that the recipient no longer needs care
e. Formal educational or vocational services related to traditional academic subjects or vocational training;
f. Experimental or investigations procedures, technologies, or non-drug therapies and related services;
g. Drugs classified as "ineffective" by FDA Drug Evaluations; and
h. Activity therapy, group activities, and other services which are primarily recreational or diversional in nature.

Treatment Plan

An individualized treatment plan used in non-accredited residential treatment centers or group homes must be developed by a team of professionals in consultation with recipients, parents, legal guardians or others in whose care recipients will be released after discharge. The plan must be developed within fourteen (14) days of the recipient's admission.

a. The interdisciplinary team must review the treatment plan at least every thirty (30) days.
b. The following must be contained in the treatment plan or documents used in the development of the treatment plan. The treatment plan and all supporting documentation must be available for review in the recipient's file:
    i. Statement of the nature of the specific problem and the specific needs of the recipient;
    ii. Description of the functional level of the recipient, including the following:
        - Mental status assessment;
        - Intellectual function assessment;
        - Psychological assessment;
        - Educational assessment;
        - Vocational assessment;
        - Social assessment;
        - Medication assessment; and
        - Physical assessment.
    iii. Statement of the least restrictive conditions necessary to achieve the purposes of treatment;
    iv. Description of intermediate and long-range goals, with the projected timetable for their attainment and the duration and scope of therapy services;
    v. Statement and rationale of the plan of treatment for achieving these intermediate and long-range goals, which includes provisions for review and modification of the plan;

vi. Specification of staff responsibilities, description of proposed staff involvement, and orders for medication(s), treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the recipient; and
vii. Criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge, and projected date of discharge.

2. Admission Criteria (Meets A, B and C, and either D or E):

a. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in NMAC 8.305.1, and the member has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic intervention.
b. The member may manifest significant psychological or behavioral disturbances but can participate in age-appropriate community based activities (including school) with assistance from group home staff or with other support.
c. Less restrictive or intensive levels of treatment have been tried and shown to be inadequate to meet the member's needs. Documentation exists to support these contentions.
d. A structured home-based living situation is unavailable or is not appropriate for the member's needs.
e. The member is in need of 24-hour therapeutic milieu, but does not require the intensive staff assistance that is provided in Residential Treatment Center Services.

3. Continued Stay Criteria (Meets All):

a. The member continues to meet admission criteria.
b. The member continues to need 24-hour supervision and assistance to develop or restore skills and behaviors that are necessary to live safely in the home and community.
c. An individualized treatment plan that addresses the member's specific symptoms and behaviors that required Group Home treatment has been developed, implemented and updated, with the member's and/or guardian's participation whenever possible, which includes consideration of all applicable and appropriate treatment modalities. The treatment and therapeutic goals are objective, measurable and time-limited
d. The current or revised treatment plan can be reasonable expected to bring about significant improvements or progress to address the goals of treatment. Progress is documented toward treatment goals
e. An individualized discharge plan has been developed which includes specific realistic, objective and measurable discharge criteria and plans for appropriate follow-up care. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met.
f. The member is participating in treatment, or there are active, persistent efforts being made that can reasonably be expected to lead to the member's engagement in treatment.
g. The parent, guardian or custodian is participating in the treatment, discharge and/or permanency planning, or persistent efforts are being made and documented to involve them, unless it is clinically indicated otherwise.

4. Discharge Criteria (Meets A or B, and C and D):

a. The member has met his/her individualized discharge criteria.

b. The member has not benefited from Group Home services despite documented persistent efforts to engage the member.
c. The member can be safely treated at a less intensive level of care
d. An individualized discharge plan with appropriate, realistic and timely follow-up care is in place.

5. Exclusionary Criteria (May Meet Any):

a. There is evidence that the Group Home placement is intended as an alternative to incarceration or community corrections involvement, and medical necessity have not been met.
b. There is evidence that the Group Home treatment episode is intended to defer or prolong a permanency plan determination. The inability of unwillingness of a parent or guardian to receive the member back into the home is not grounds for continued Group Home care.
c. The individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.
d. MCO Quality of Service Criteria # 5 has not been met: The member's current condition cannot be effectively and safely treated in a lower level of care even when the treatment plan is modified, attempts to enhance the member's motivation have been made, or referrals to community resources or peer supports have been made.
e. MCO Quality of Service Criteria # 8 has not been met: Treatment is not primarily for the purpose of providing respite for the family, increasing the member's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.

K. Applied Behavior Analysis (ABA)

1. Definition of Service:

ABA services are provided to a Medical Assistance Programs (MAP) eligible member 12 months up to 21 years of age. A member's eligibility for ABA service falls into one of two categories: "At Risk for Autism Spectrum Disorder (ASD)" or "Diagnosed with ASD." An eligible member must meet the level of care (LOC) Criteria detailed below, which includes medically necessary criteria.

Medically necessary services

a. Medically necessary services are clinical and rehabilitative physical or behavioral health services that:
    i. are essential to prevent, diagnose or treat medical conditions or are essential to enable an eligible member to attain, maintain or regain functional capacity;
    ii. are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical and behavioral health care needs of the eligible member;
    iii. are provided within professionally accepted standards of practice and national guidelines; and
    iv. are required to meet the physical and behavioral health needs of the eligible member and are not primarily for the convenience of the eligible member, the provider or the payer.
b. Application of the definition:

i. A determination that a service is medically necessary does not mean that the service is a covered benefit or an amendment, modification or expansion of a covered benefit, such a determination will be made by MAD or its designee.

ii. The department or its authorized agent making the determination of the medical necessity of clinical, rehabilitative and supportive services consistent with the specific program's benefit package applicable to an eligible member will do so by:

- evaluating the eligible member's physical and behavioral health information provided by qualified professionals who have personally evaluated the eligible member within their scope of practice, who have taken into consideration the eligible member's clinical history including the impact of previous treatment and service interventions and who have consulted with other qualified health care professionals with applicable specialty training, as appropriate;
- considering the views and choices of the eligible member or their personal representative regarding the proposed covered service as provided by the clinician or through independent verification of those views; and
- considering the services being provided concurrently by other service delivery systems.

iii. Physical and behavioral health services will not be denied solely because the eligible member has a poor prognosis. Required services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible member solely because of the diagnosis, type of illness or condition

iv. Decisions regarding MAD benefit coverage for eligible members under 21 years of age will be governed by the early periodic screening, diagnosis and treatment (EPSDT) coverage rules.

v. Medically necessary service requirements apply to all medical assistance program rules.

2. Admission Criteria for Diagnosed with ASD and At-Risk for ASD (Must meet A-G for admission):

a. Services are determined to be medically necessary per NMAC 8.302.1.7.

b. The eligible member cannot adequately participate in home, school, or community activities because the presence of behavioral excesses (i.e. socially significant behaviors) and/or the absence of functional skills interfere with meaningful participation in these activities; and/or

c. The eligible member presents a safety risk to self or others. (The presence of safety risk to self or others does not need to meet the threshold criteria for out-of-home placement.)

d. There is a reasonable expectation that ABA services will result in measurable improvement in the acquisition of functional, adaptive skills, and/or the reduction of non-functional, maladaptive behavior.

e. The eligible member's caregivers are able to participate and commit meaningfully to ABA interventions and activities to be conducted outside the formal treatment environment.

f. The eligible member follows the prescribed three-stage comprehensive approach to evaluation, assessment, and treatment as outlined in the MAD ABA Billing Instructions.

g. The eligible member meets one of the following two categories:

i. *At-risk for ASD*: eligible A member may be considered At-Risk for ASD, and therefore eligible for time-limited, Focused ABA Services if he or she does not meet full criteria for ASD per the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD), and when he or she meets all of the following criteria:
   - Is between 12 and 36 months of age;
   - Presents with developmental differences and/or delays as measured by standardized assessment;
   - Demonstrates some characteristics of the disorder (e.g., impairment in social communication and early indicators for the development of restricted and repetitive behavior);
   - Presents with at least one genetic risk factor (e.g., the eligible member has genetic risk due to having an older sibling with a well-documented medical diagnosis of ASD; the eligible member has a diagnosis of Fragile X syndrome).

ii. *Diagnosed with ASD:* An eligible member 12 months up to 21 years of age who has a medical diagnosis of ASD according to the latest DSM or ICD criteria is eligible for ABA services if the evaluation leading up to a diagnosis of ASD meets service requirements as stated in NMAC 8.321.2 (10.C*) Covered services -stage 1*.

iii. When a member has been diagnosed with ASD within the last 12 months by an in-state or out-of-state provider who meets Stage 1 provider requirements, an ICD may be developed.

3. Continued Eligibility Criteria (Must meet A through C, or both A and D for continuation):

a. The eligible member continues to meet the ABA admission criteria.
b. There is evidence the child, family, and social supports can continue to participate effectively in this service.
c. The eligible member responds positively to ABA services, as evidenced by quantitative data submitted by the ABA Provider (AP) when requesting prior authorization for continuation of ABA services.
d. When the eligible member does not respond positively to ABA services, as evidenced by quantitative data and clinical information submitted by the ABA Provider (AP) when requesting prior authorization for continuation of ABA services, the treatment plan and the treatment plan report (i.e., graphs, peer review) must be updated to reflect what interventions will be changed to produce measurable gains.

4. Discharge Criteria (Must meet one of A-D for discharge):

Individualized discharge criteria are developed with appropriate, realistic, and timely follow-up care and these criteria are included in the initial or most current ABA Treatment Plan. An eligible member may be discharged from ABA services when any of the following are present:

a. The eligible member has met his or her individualized discharge criteria.
b. The eligible member has reached the defining age limit as specified for At-Risk for ASD eligibility which is up to 3 years of age, or for Diagnosed with ASD eligibility which is under 21 years of age.
c. The eligible member can be appropriately treated at a less intensive level of care.

d. The eligible member requires a higher level of care, which includes out-of-home placement.

Note: Out-of-home placement would not include treatment foster care because ABA services could continue at that level of care.

5. Exclusionary Criteria (Must meet one of A-F for exclusion):

An eligible member may be excluded from ABA services when any of the following are present:

a. The eligible member's Comprehensive or Targeted Diagnostic Evaluation or the ISP and/or Treatment Plan Updates recommend placement in a higher, more intensive, or more restrictive LOC (Not to include treatment foster care: See note in Section III.).
b. The eligible member's provider, such as psychiatrist, recommends higher LOC.
c. The eligible member is in an out-of-home placement (Not to include treatment foster care: See note in Section III). An exception is that time limited ABA services may be authorized while the member remains in the out-of-home facility for transition when ABA services are approved to be rendered upon his or her discharge from the facility to a community ABA provider.
d. The referral for the Comprehensive Diagnostic Evaluation did not follow the Eligibility requirements defined in 8.321.2 Section 10(B).
e. The member has reached the maximum age for ABA services.
f. Family/caregiver is unable to participate in the treatment plan.

L. Electroconvulsive Therapy (ECT)

1. Service Description:

For use as a treatment for severe depression that has not responded to other treatment. Short-term ECT is given for a limited number of times per week for a limited number of weeks. Maintenance ECT is provided as required; maintenance ECT is provided less frequently than short-term ECT, i.e. once per week/two weeks/month. Short-term ECT & Maintenance ECT is typically for adults but will evaluate for pediatric population on a case by case basis.

2. Criteria for Approval (Must meet all):

a. Medical necessity has been demonstrated according to the member's clinical needs and the member has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic intervention.
b. A second opinion from a psychiatrist confirms that ECT is an appropriate treatment for the member.
c. A medical evaluation indicates no contraindication for ECT.
d. Informed consent for ECT has been obtained and documented in the treatment record.
e. The member has treatment resistant depression or psychotic disorder, is experiencing a severe or prolonged manic episode unresponsive to usual treatments, cannot tolerate usual psychotropic medications, exhibits food refusal leading to nutritional compromise or is experiencing such intense suicidal ideation that there is an urgent need for response, or it is the member's choice for treatment.

3. Criteria for Maintenance Electroconvulsive Therapy (Must Meet All):

a. The member meets the criteria for approval for ECT as outlined above, received ECT, and had a positive response.
b. Other treatment options are not viable for the member.
c. A second opinion from another (other than the current treating psychiatrist) is obtained every 6 months documenting the need for maintenance ECT.

M. Transitional Living Services (TLS)

1. Service Description:

Transitional Living Services (TLS) is a residential program offering 24-hour supervised treatment services in a structured, community-oriented environment for consumers 17 years of age and older. TLS includes organized rehabilitation services, as well as assistance in obtaining appropriate long-term living arrangements. The services are designed for individuals who have the potential and motivation to change some skills deficits through a moderately structured rehabilitative program. Services stress normalization and maximum community involvement and integration. They include daily living and socialization skills training; community supports; recreational activities; educational and support activities; and access to therapeutic interventions, when necessary.

The focus of services is on placement of the individual in a safe and stable living environment upon discharge from the transitional residential living arrangement. These residential services are treatment-oriented and are not considered custodial care or merely a housing option. There is a 180 day maximum, per member, per calendar year, based on medical necessity.

2. Admission Criteria (Must Meet All):

a. The member has a DSM 5 diagnosed condition that requires, and is likely to benefit from, therapeutic intervention.
b. The member has behavioral health symptoms that interfere significantly with his or her ability to manage activities of daily living without structured intervention, and these symptoms prevent successful transition to independent living. It is anticipated that the member possesses the intellectual capacity to develop, maintain, or regain daily living skills through participation in a structured TLS program.
c. Participating in this level of care may assist the member in avoiding a more restrictive level of care.
d. Any member evaluated for this benefit will be expected to participate in the recommended treatment while in this level of care.

3. Continuing Stay Criteria (Must Meet All):

The member continues to meet the criteria for admission.

a. An individualized treatment plan that addresses the member's specific symptoms and behaviors that required Transitional Living Services has been developed, implemented and updated, with the member's and/or guardian's participation whenever possible, which includes consideration of all applicable and appropriate treatment modalities.
b. An individualized discharge plan has been developed which includes specific, realistic, objective and measurable discharge criteria and plans for appropriate follow-up care.

A timeline for expected implementation and completion is in place but discharge criteria have not yet been met.

c. There is documentation that the member is participating in the services or is learning to actively participate in self directed recovery and resiliency activities.

4. Discharge Criteria (Must Meet A and B or C or D):

a. An individualized discharge plan with appropriate, realistic and timely follow-up care is in place.
b. The member has substantially met the defined goals of the treatment plan and is able to live independently.
c. Member elects to terminate this level of care.
d. The member has not benefited from this level of care.

5. Exclusionary Criteria (May Meet Any):

a. There is evidence that the TLS placement is intended as an alternative to incarceration or community corrections involvement.
b. There is evidence that the TLS treatment episode is intended to defer or prolong a permanency plan determination.
c. The member demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.

N. Non-Hospital Based Inpatient Detox and Outpatient Detox

1. Service Description:

These services will be provided for individuals with substance abuse disorders in need of detoxification in either a non-hospital inpatient setting or in an outpatient setting, according to individual clinical needs. Services will be provided by qualified substance abuse treatment centers. These services can be effective alternatives to higher levels of care (e.g. Hospital based detox). Services are for age 14 and above. Inpatient stay is for 5-7 days. Outpatient stays are for up to 10 days. Services are limited to 1 non-hospital inpatient detox admissioin or 2 outpatient detoxes per calendar year per Member.

2. Admission, Continuing Stay Criteria, and Discharge Criteria

Based upon most recent ASA

O. Infant Mental Health (IMH)

1. Service Description:

Infant Mental Health Services (IMH) targets children (0-5) in distress or with clear symptoms indicating a mental health disorder. IMH address problems with attachment and relationships in families, focus on the parent-child relationship, and are designed to improve infant and family functioning in order to reduce risk for more severe behavioral, social, emotional, and relationship disturbances as infants get older. Relationship-focused interventions to the parents, foster parents, or other primary caregivers with infants and toddlers.

2. Criteria for Approval ((Must Meet All):

a. Before engaging in IMH Treatment Services, the infant must have a comprehensive treatment file containing the following:

i. One infant mental health diagnostic evaluation.
ii. One individualized service plan that includes IMH Treatment Services as an intervention.

b. At least 80% of IMH services need to be provided *in vivo* in the home or other settings natural to the infant and family.
c. Infant/parent psychotherapy must be provided by an endorsed level 3 or 4 infant mental health specialist.
d. In addition, providers of this service must have the capacity to:
    i. Coordinate with other children's serving systems to address the infant and caregiver's concrete, developmental and environmental needs; and
    ii. Provide guidance to parents/caregivers with information and strategies that address an infant's social and emotional capacities, as well as parental/caregiver strengths.

Section 8 – Care Management / Care Coordination

A. Care Management / Care Coordination Overview

Molina Healthcare's Integrated Care Management, which includes Utilization Management, Case Management (known as Care Coordination under the Centennial Care Program), 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 to providers or by Members to providers, assisting to identify resources such as community programs, national support groups, appropriate specialists, appropriate facilities, identifying best practices or new and innovative approaches to care. Care coordination by Molina Healthcare staff is done in partnership with providers and members to ensure efforts are efficient and non-duplicative.

Molina Healthcare recognizes the emotional impact the diagnosis of a serious or catastrophic illness can have on their patients. Molina Healthcare has a Care Management/Care Coordination program that can help providers better manage patients' health. The Health Care Services Department has the clinical experience that enables us to respond quickly to patient needs. This clinical experience helps us coordinate care for many different illnesses and conditions, including, but not limited to:

- Acute Diseases;
- Behavioral Health Diagnoses including Substance Abuse that adversely affects the patient's life;
- Progressive arthritic conditions;
- Cancer;
- Congestive Heart Failure;
- Dependent child in out-of-home placements;
- Dementias/deteriorating cognitive abilities;
- Epilepsy;
- High-risk pregnancies;
- Hospital readmissions within thirty (30) days;
- ICF/MR/DD;
- Medically fragile;
- Muscular/neuromuscular degenerative diseases; and
- Transplants.

Practitioners/providers must contact the Molina Care Manager/Care Coordinator should any of the following conditions occur:

- Inability to contact Member;
- Inability to provide services;
- Change in the Member's condition;
- Member unexpectedly leaves their place of residence or without notification;
- Member is transferred to the hospital;

- Member suffers a fall;
- Skin integrity issues;
- Hospice election;
- Bed hold and therapeutic leave requests (Skilled Nursing Facilities only); and
- Death of the Member.

The earlier you provide notification of these cases, the sooner Molina Healthcare can begin working with you to maximize the patient's health coverage benefits. Members can be referred to Molina Healthcare for Care Coordination by telephone or fax via the following:

Complex Medical Care Management/Care Coordination Review t oll free fax: (866) 472-4575

Care Coordination/ Care Management Referral Forms can be accessed via the Molina Healthcare Provider Portal at: Care Coordination Form

B. Role of the Care Manager/Care Coordinator

Molina Healthcare provides care coordination that includes the following functions:

- Performs a Health Risk Assessment (HRA) and assigns Members to Care Management Level 23;
- Comprehensive needs assessments (including level of care);
- Determines the Member's physical and behavioral health, and long-term care needs;
- Develops and updates of a Comprehensive Care Plan based upon the Member's individual needs and preferences; and
- On-going coordination services based upon Member's assessed need.

The PCP serves as the point of initial contact and as the Member's "medical home." In addition to the PCP, other practitioners/providers are included in the care management process. Specialists, therapists, home and community-based providers, subcontractors and other practitioners/providers – including those that are out-of-network – are included in the Interdisciplinary Care Team, as appropriate, and provide input into the development of the Member's treatment plan or ISP and care planning process.

Care Managers/Care Coordinators work with these practitioners/providers to coordinate services and provide updates on the results of Member assessments. Practitioners/providers should contact the Member's Care Manager/Care Coordinator or the Member's PCP if they detect a change in the Member's condition.

Primary care teams consisting of residents and a supervising faculty physician for contracts with teaching facilities or teams which include certified mid-level practitioners who, at the Member's request, may serve as the point of first contact. Molina Healthcare will organize its team to ensure continuity of care to Members and will identify a "lead physician" within the team for each Member. The "lead physician" will be an attending physician (medical students, interns and residents may not serve as "lead physician").

The Member plays a critical role in Molina's Care Management Model. Self-management support helps the Member understand how medical, behavioral, social, and cultural influences drive decisions regarding healthcare.

Molina Healthcare has in place several initiatives to promote continuity and coordination of services. These activities incorporate processes that occur at various stages of the health care continuum as well as addressing changes in the status of the Member. These processes include, but are not limited to:

- Evaluation of continuity and coordination of care, including reevaluation upon a change in condition;
- Coordination of all medical care;
- Coordination of care between behavioral health and medical care;
- Continuity after practitioner termination;
- Member notification of PCP and specialist termination;
- Continuity of care upon new Member effective date of enrollment; and
- Continuity of care following Member loss of eligibility.

C. Coordinating Medical Services

Well-documented medical records demonstrating coordination of care, whether electronic or on paper, facilitate communication, coordination, and continuity of care and promotes the efficiency and effectiveness of treatment. Molina Healthcare Care Managers will conduct record reviews to assess:

- Does the PCP refer patients to behavioral health providers as appropriate? A re specialty practitioners reports in the patients file?
- Are diagnostic tests results in the patients file?
- Is there a note about the patient being told by the practitioner of abnormal results of any laboratory, imaging or other testing?
- Are reports of emergency care in the patient's file?
- Are therapeutic–physical therapy (PT), occupational therapy (OT), speech/language SLP) – reports in the patient's file?
- Is home health nursing reports in the patient's file?
- Are hospital inpatient or discharge reports in the patient's file?
- Are surgery center reports in the patient's file? and
- Are nursing facility reports in the patients file?

Section 9 – Health Management

Molina Healthcare provides health management services to at-risk Members who have asthma, diabetes, chronic obstructive pulmonary disease (COPD), and cardiovascular disease (CVD). Molina Healthcare is in the process of developing additional health management programs to meet the needs of Members with Behavioral Health diagnoses and Members receiving Long Term Care services.

Molina Healthcare's health management programs are designed to assist your patients who have chronic health conditions better understand his/her condition, update him/her on new I itionally, all identified Members will receive periodic educational newsletters.

Heart Healthy Living[sm]

Molina Healthcare has a health management program called ***Heart Healthy Living***[sm] designed to teach Members how to manage their heart disease. Each identified Member will receive educational materials about heart disease, hypertension and/or congestive heart failure and ways to stay healthy. Additionally, all identified Members will receive periodic educational newsletters.

motherhood matters[sm] Pregnancy Program

Molina Healthcare also offers a voluntary educational program for pregnant Members called the ***motherhood matters***[sm] **Program.**

Molina Healthcare cares about the health of your pregnant patients and their new babies. You can take advantage of better support and care for your patients when you refer your pregnant patients to our ***motherhood matters***[sm] Pregnancy Program. Your patients will be given additional education, guidance and resources.

Members enrolled in the ***motherhood matters***[sm] Pregnancy Program receive a free infant car seat for completing the prenatal education and car seat safety education program. They also receive a free convertible (toddler) car seat for completing a postpartum check-up within three (3) to eight (8) weeks after delivery of their newborn.

Call Molina Healthcare's Health Improvement hotline **toll free at (800) 377-9594**, **extension 182618** to refer a patient or for more information regarding this program. This information is also available on Molina Healthcare's website at www.molinahealthcare.com

Pregnancy Notification Diagnosis Reimbursement

Molina Healthcare continues to offer ***additional reimbursement*** to providers for pregnancy notification. When you diagnose a Molina Healthcare Member with a confirmed pregnancy you can receive a $100 notification incentive. **Effective October 1, 2015, please use ICD-10 Z32.01 (Encounter for pregnancy test, result positive)** when submitting notification and claim for reimbursement.

Prenatal Visit and Postpartum Visit Incentive

Molina Healthcare also provides ***additional reimbursement*** to providers for up to thirteen (13) prenatal visits and a postpartum visit preferably within three (3) to eight (8) weeks after delivery.

Prenatal Care: Receive $30 for each visit, up to thirteen (13) visits:
- CPT II code 0500F – Initial prenatal care visit; and
- CPT II code 0502F – Subsequent prenatal visits.

Postpartum Care: Receive $30 for postpartum visit:
- CPT II code 0503F.

If you have any questions, please call Provider Services toll free at (800) 377-9594, Monday through Friday between 8:00 a.m. and 5:00 p.m.

Manage Your Chronic Disease (MyCD) Program

Molina Healthcare has a FREE evidence-based lifestyle change program for Members with a chronic health condition such as diabetes, asthma, high blood pressure, heart disease, etc. The Chronic Disease Self-Management Program (CDSMP)/Manage Your Chronic Disease (MyCD) Program ***can help people gain the self- confidence necessary to take part in maintaining their health and managing their chronic health condition.***

The **CDMSP/*MyCD Program*** was developed by Stanford University. Results of their research conducted on the ***MyCD Program*** earned the program as "evidence based" due to predictably positive results for those participants who attended regularly. This peer-led education program is delivered in community settings such as senior centers, community centers, churches, libraries and hospitals. The program is for adults of all ages with chronic conditions. Family, friends and caregivers are also welcome.

Classes are held in small groups and meet for 2½ hours, once (1) a week for six (6) weeks. The highly interactive workshops are led by pairs of trained leaders, most of who have a chronic condition themselves and may have successfully adopted the techniques taught in the program. The workshops cover skill-building techniques to deal with challenges such as:
- Frustration, fatigue, pain and isolation;
- Appropriate exercise for maintaining and improving strength,
- Flexibility and endurance;
- Appropriate use of medications;
- Communicating effectively with health professionals, family and friends; and
- Eating healthy.

Molina Healthcare practitioners/providers play a powerful role in the success of this program. Patients have stated that receiving a referral from their provider would be the most powerful motive to join the program.

To register Molina Healthcare Members for the MyCD classes call Molina Healthcare's Health Improvement Hotline toll free at (800) 377-9594, extension 182618 or (505) 342-4660, extension 182618 in Albuquerque.

National Diabetes Prevention Program (NDPP)

Molina Healthcare has another FREE lifestyle change program called the National Diabetes Prevention Program. This evidence-based program is from the Centers for Disease Control and Prevention (CDC). The program is available for Members who are risk for diabetes (prediabetes). The program is a 16-week lifestyle change program that helps lower Members' risk for type 2 diabetes through learning healthy changes, increasing physical activity and losing weight. Coaching sessions meet weekly for 16

weeks. After the 16 weeks, the sessions meet monthly for six (6) months for additional support. To qualify for this program, Members must be at least 18 years of age AND have one of the following: BMI of 24 or higher (22 or higher for Asian), elevated fasting or two (2) hour glucose tolerance, HbA1C (5.7 – 6.4) glucose levels, a history of gestational diabetes and/or family history of diabetes.

To refer Molina Healthcare Members for the NDPP classes, call Molina Healthcare's Health Improvement Hotline toll free at (800) 377-9594, extension 182618 or (505) 342-4660, extension 182618 in Albuquerque.

Medication Therapy Management Program (MTM) – Your Prescription for Better Health

Molina Healthcare in collaboration with the University of New Mexico College of Pharmacy Medication Therapy Management Center offers Members the services of pharmacists by appointment to assist with their medication issues. Appointments are available by phone or office visit. Referrals are suggested for Members with medication adherence problems who want to learn about how and why their medication therapy is important. Referrals can be made by contacting the Molina Healthcare Pharmacy Management Department at (888) 825-9266 extension 186336.

Section 10 – Pharmacy Management

A. Formulary (Preferred Drug List)

The development and maintenance of the Molina Healthcare formulary, or Preferred Drug List (PDL) is overseen by the Molina Healthcare, Inc. Pharmacy and Therapeutics (P&T) Committee, the mission of which is to ensure access to the medications and treatments that meet or exceed established standards for the delivery of quality care. This committee meets quarterly and is comprised of physicians and pharmacists from within the company as well as contracted providers.

The purpose of the PDL is to assist in maintaining the quality of patient care by providing a range of safe and effective medications to the Members. The Molina Healthcare formulary is classified as a closed formulary, which necessitates requests for prior authorization (PA) related to drugs not listed on the formulary. Contracted providers are requested to refer to the Molina Healthcare of New Mexico PDL when selecting prescription drug therapy for eligible plan Members. The PDL may be accessed and printed via the Molina Healthcare website via the following link: Molina Healthcare Formulary . Paper copies of the Molina Healthcare PDL may also be obtained by calling the Member Service Department in **Albuquerque at** (**505) 341-7493**.

The New Mexico Universal Drug Prior Authorization Request Form may be downloaded for fax via this link - Drug Prior Authorization Form

B. 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 only through Molina Healthcare's exclusive specialty pharmacy - Caremark Specialty Pharmacy. More information about our Prior Authorization process, including a PA request form, is available in Section 6 of this manual.

Caremark will coordinate with Molina Healthcare and ship the prescription directly to your office or the Member's home. All packages are individually labeled 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 the Pharmacy Management Department or your Provider Relations Representative with any further questions about the program.

C. Non-Formulary Requests for Specialty/ Injectable Medication

These medications generally require a prior authorization or are managed in terms of the number of doses allowed in a given time span. When requesting a prior authorization for injectable medications, complete a copy of the New Mexico Universal Drug Prior Authorization Request Form (See Section A above) and fax it to Molina Healthcare Pharmacy Management Department in **Albuquerque toll free number (866) 472-4578.** Please include all pertinent medical necessity documentation that justifies the use of a non-formulary medication as well as the expected duration of therapy. Molina Healthcare will review the request and evaluate it according to established guidelines. The resulting decision will be communicated to both the prescriber and the Member.

Approved injections supplied by and administered in a practitioner's office should be billed electronically or on a CMS-1500 form.

D. Non-Formulary Requests for Oral Medications

Complete the New Mexico Universal Drug Prior Authorization Request Form – Medication Prior Request Form and fax it to the Molina Healthcare Pharmacy Management Department in Albuquerque at the **toll free number (866) 472-4578.** Please include all pertinent medical necessity documentation that justifies the use of a non-formulary medication as well as the expected duration of therapy. Molina Healthcare will review the request and evaluate it according to established guidelines. The resulting decision will be communicated to both the prescriber and the Member.

E. Formulary Addition Requests From Practitioners

We value and want your feedback. Molina Healthcare, Inc. convenes a Pharmacy & Therapeutics (P&T) Committee to review formulary changes. The committee is composed of Molina staff and actively practicing, contracted physicians of various specialties and pharmacists.

To request a Formulary Addition, please download the request form at this link – Formulary Addition Request Form Please fax it to Molina Healthcare in **Albuquerque at (505) 348-0299.** The P&T Committee will review the request as soon as possible and communicate its decision to the requesting practitioner.

F. Medicare Part D Pharmacy Benefit

Dual Eligible Molina Healthcare Members (Members enrolled in both Medicare and Medicaid) will receive their primary pharmacy coverage through Medicare Part D. Molina Healthcare will provide wrap-around prescription drug coverage for selected Medicaid members that are on medications in drug classes not covered through Medicare Part D (mostly non-prescription drugs). By law, Medicaid cannot cover drugs not covered by Medicare because they are non-formulary or for which prior authorization was denied nor are Medicare Part D copayments covered. Medicare Prescription Drug coverage is available through the Members Medicare Advantage Prescription Drug Plans (MA-PD and standalone Prescription Drug Plans (PDP).

Medicare Part D is a built-in benefit. Members participating in Molina's Medicare Special Needs Plan (SNP) called "Options Plus" automatically receive Medicare Part D coverage. There are no forms to fill out or selections to make. Molina handles the paperwork for all Members participating in the Molina Medicare SNP.

Section 11 – Credentialing / Recredentialing

The purpose of the Credentialing Program is to strive to assure that the Molina Healthcare network consists of quality 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 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.

A. Criteria for Participation in the Molina Healthcare Network

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

To remain eligible for participation Providers must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Molina Healthcare.
Molina reserves the right to exercise discretion in applying any criteria and to exclude Providers who do not meet the criteria. Molina may, after considering the recommendations of the Credentialing Committee, waive any of the requirements for network participation established pursuant to these policies for good cause if it is determined that such waiver is necessary to meet the needs of Molina and the community it serves. The refusal of Molina to waive any requirement will not entitle any Provider to a hearing or any other rights of review.

Providers must meet the following criteria to be eligible to participate in the Molina Healthcare network. If the Provider fails to meet/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. Providers who fail to provide proof of meeting these criteria do not have the right to submit an appeal.

1. Provider must practice, or plan to practice within 90 calendar days, within the area served by Molina.
2. All Providers, including ancillary Providers, (i.e. vision, pharmacy, etc.), will apply for enrollment in the Medicaid program. Providers are required to have an NPI or an Administrative Provider Identification Number (APIN).
3. Provider must complete and submit to Molina a credentialing application. The application must be entirely complete. The Provider must sign and date that application attesting that their application is complete and correct within 180 calendar days of the credentialing decision. If Molina or the Credentialing Committee requests any additional information or clarification the Provider must supply that information in the time-frame requested.
4. Provider must have a current, valid license to practice in their specialty in every state in which they will provide care for Molina Members.
5. If applicable to the specialty, Provider must hold a current and unrestricted federal Drug Enforcement Agency (DEA) certificate and Controlled Substance Certification or Registration.

If a Provider has never had any disciplinary action taken related to his/her DEA or CDS and chooses not to have a DEA or CDS, the Provider may be considered for network participation if they submit a written prescription plan describing the process for allowing another Provider with a valid DEA or CDS certificate to write all prescriptions. If a Provider does not have a DEA because of disciplinary action including but not limited to being revoked or relinquished, the Provider is not eligible to participate in the Molina network.

6. Providers will only be credentialed in an area of practice in which they have adequate education and training as outlined below. Therefore Providers must confine their practice to their credentialed area of practice when providing services to Molina Members.
7. Providers must have graduated from an accredited school with a degree required to practice in their specialty.
8. Oral Surgeons and Physicians (MDs, DOs) must have satisfactorily completed a training program from an accredited training program in the specialty in which they are practicing. Molina 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).
9. Board certification in the specialty in which the Provider 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 recognizes Board Certification only from the following Boards:
    a. American Board of Medical Specialties (ABMS)
    b. American Osteopathic Association (AOA)
    c. American Board of Podiatric Surgery (ABPS)
    d. American Board of Podiatric Medicine (ABPM)
    e. American Board of Oral and Maxillofacial Surgery
10. Providers 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 Provider in the Molina network. To be eligible, the Provider 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.
11. Provider 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 Provider 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 determines there is a gap in work history exceeding six-months, the Provider must clarify the gap either verbally or in writing. Verbal communication must be appropriately documented in the credentialing file. If Molina determines there is a gap in work history that exceeds one-year, the Provider must clarify the gap in writing.
12. Provider 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 Provider 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 Provider.
13. Provider must disclose a full history of all license actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations and non-

renewals. Provider 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 Provider.

14. At the time of initial application, the Provider must not have any pending or open investigations from any state or governmental professional disciplinary body.[25]. This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.
15. Provider must disclose all Medicare and Medicaid sanctions. Provider must disclose all debarments, suspensions, proposals for debarments, exclusions or disqualifications under the nonprocurement 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 Provider.
16. Provider 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.
17. Provider must have and maintain current professional malpractice liability coverage with limits that meet Molina criteria. This coverage will extend to Molina Members and the Providers activities on Molina's behalf.
18. Provider must disclose any inability to perform essential functions of a Provider 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 Provider.
19. Provider 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 Provider. If a Provider discloses any issues with substance abuse (e.g. drugs, alcohol) the Provider must provide evidence of either actively and successfully participating in a substance abuse monitoring program or successfully completing a program.
20. Provider 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 Provider.
21. Provider 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.
22. Provider must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Provider has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.
23. Physicians (MD, DO), Primary Care Providers, Nurse Midwives, Oral Surgeons, Podiatrists and/or those Providers dictated by state Law, must have admitting privileges in their specialty. If a Provider chooses not to have admitting privileges, the Provider may be considered for network participation if they have a plan for hospital admission by using a Hospital Inpatient Team or

[25] If a Provider's application is denied solely because a Provider has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the Provider may reapply as soon as Provider 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.

having an arrangement with a credentialed Molina participating Provider that has the ability to admit Molina patients to a hospital. Providers practicing exclusively on a consultative basis are not required to have admitting hospital privileges. Physicians practicing in Dermatology, Occupational Medicine, Pain Medicine, Physical Medicine and Rehabilitation, Psychiatry, Sleep Medicine, Sports Medicine, Telemedicine, Urgent Care and Wound Management do not require admitting privileges.

24. Providers 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.
25. Providers currently listed on the Medicare Opt-Out Report may not participate in the Molina network for any Medicare line of business.
26. If applicable to the specialty, Provider 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 Provider(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 Providers must have 24-hour coverage. Physicians practicing in Dermatology, Occupational Medicine, Pain Medicine, Physical Medicine and Rehabilitation, Sleep Medicine, Telemedicine, Sports Medicine, Urgent Care and Wound Management are not required to have 24-hour coverage.
27. Molina may determine, in its sole discretion, that a Provider is not eligible to apply for network participation if the Provider is an employee of a Provider or an employee of a company owned in whole or in part by a Provider, who has been denied or terminated from network participation by Molina, who is currently in the Fair Hearing Process, or who is under investigation by Molina. Molina also may determine, in its sole discretion that a Provider cannot continue network participation if the Provider is an employee of a Provider or an employee of a company owned in whole or in part by a Provider, who has been denied or terminated from network participation by Molina. For purposes of this criteria, a company is "owned" by a Provider when the Provider has at least 5% financial interest in the company, through shares or other means.
28. Providers 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, Provider must meet all criteria for participation outlined above.
29. Providers 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, Provider must meet all criteria for participation as outlined above.
30. Providers denied or terminated administratively are eligible to reapply for participation anytime as long as the Provider meets all criteria for participation above.

B. Burden of Proof

The Provider will 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 Provider without limitation, including physical and mental health status as allowed by Law, and the burden of resolving any doubts about these or any other qualifications to participate in the Molina Healthcare network. If the Provider 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. Providers who fail to provide this burden of proof do not have the right to submit an appeal.

C. Provider termination and reinstatement

If a Provider's contract is terminated and later it is determined to reinstate the Provider, the Provider 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 Provider's reentry into the network. Not all elements require re-verification; for example, graduation from medical school or residency completion does not change. If the contract termination was administrative only and not for cause, if the break in service is less than 30 calendar days, the Provider can be reinstated without being initially credentialed.

If Molina Healthcare is unable to recredential a Provider within 36-months because the Provider is on active military assignment, maternity leave or sabbatical but the contract between Molina and the Provider remains in place, Molina Healthcare will recredential the Provider upon his or her return. Molina Healthcare will document the reason for the delay in the Provider's file. At a minimum, Molina Healthcare will verify that a Provider who returns has a valid license to practice before he or she can resume seeing patients. Within 60 calendar days of notice when the Provider 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 Provider before the Provider rejoins the network.

D. Providers Terminating With a delegate and Contracting With Molina Healthcare Directly

Providers credentialed by a delegate who terminate their contract with the delegate and either have an existing contract with Molina or wish to contract with Molina Healthcare directly must be credentialed by Molina Healthcare within six-months of the Provider's termination with the delegate. If the Provider has a break in service more than 30 calendar days, the Provider must be initially credentialed prior to reinstatement.

E. Credentialing Application

At the time of initial credentialing and recredentialing, the Provider must complete a credentialing application designed to provide Molina Healthcare with information necessary to perform a comprehensive review of the Provider's credentials. The application must be completed in its entirety. The Provider 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, unless state law requires otherwise:

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

Inability to perform essential functions and illegal drug use
An inquiry regarding illegal drug use and inability to perform essential functions may vary. Providers 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 Providers about impairments; language does not have to refer exclusively to the present, or only to illegal substances.

History of actions against applicant
An application must contain the following information, unless State Law requires otherwise:
- History of loss of license;
- History of felony convictions and;
- History of all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which a Provider has had privileges.
- History of Medicare and Medicaid Sanctions

Current malpractice coverage
The application form must include specific questions regarding the dates and amount of a Provider's current malpractice insurance. Molina may obtain a copy of the insurance face sheet from the malpractice carrier in lieu of collecting the information in the application.
For Providers with federal tort coverage, the application need not contain the current amount of malpractice insurance coverage. Provider files that include a copy of the federal tort letter or an attestation from the Provider of federal tort coverage are acceptable.

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

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

F. Turn-Around Time
In accordance with New Mexico laws and regulations, the credentialing process will be completed within 45 days from receipt of completed application with all required documentation unless there are extenuating circumstances. Molina Healthcare will take into account and make allowance for the time required to request and obtain primary source verifications and other information that must be obtained from third parties in order to authenticate the practitioner’s credentials, and will make allowance for the scheduling of a final decision.

Within forty-five (45) calendar days after receipt of a completed application and with all supporting documents, Molina Healthcare will assess and verify the practitioner’s qualifications and notify the practitioner of its decision.

If, by the 45th calendar day after receipt of the completed application, Molina Healthcare has not received all of the information or verifications it requires from third parties, or date-sensitive information has expired, Molina Healthcare will issue a written notification through standard mail, fax, or electronic mail, or other agreed upon writing, to the practitioner either closing the application and detailing Molina Healthcare's attempts to obtain the information or verification, or pending the application and detailing Molina Healthcare's attempts to obtain the information and verifications. If the application is held, Molina Healthcare will inform the practitioner that the file will be pended for forty-five (45) calendar days, once this timeframe is exhausted, if the information and verifications have not been received the file will be closed.

Incomplete Applications
Within ten (10) working days after receipt of an incomplete application Molina Healthcare will notify the practitioner in writing of all missing or incomplete information or supporting documents.

G. The Process for Making Credentialing Decisions

All Providers requesting participation with Molina must complete a credentialing application. To be eligible to submit an application, Providers must meet all the criteria outlined above in the section titled "Criteria for Participation in the Molina Healthcare Network". Providers requesting initial credentialing may not provide care to Molina Members until the credentialing process is complete and final decision is rendered.

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

During the initial and recredentialing application process, the Provider 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 Provider 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 Provider 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. Providers 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, Provider credentials 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 recommendation. The Credentialing Committee can approve, deny, terminate, approve on watch status, place on corrective action or defer their decision pending additional information.

H. 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's requirements for delegation. Molina's Delegation Oversight Committee (DOC) must approve all delegation and subdelegation arrangements, and retains the right to limit or revoke any and all delegated credentialing activities when a delegate fails to meet Molina's requirements.

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

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

- Be National Committee for Quality Assurance (NCQA) accredited or certified for credentialing or pass Molina 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.

I. 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 Provider specializes. This does not preclude Molina Healthcare from including in its network Providers who meet certain demographic or specialty needs; for example, to meet cultural needs of Members.

J. Notification of Discrepancies in Credentialing Information

Molina will notify the Provider immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the Provider. Examples include but are not limited to actions on a license, malpractice claims history or sanctions. Molina 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 Providers Right to Correct Erroneous Information.

K. Notification of Credentialing Decisions

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

L. Confidentiality and Immunity

Information regarding any Provider or Provider submitted, collected, or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care will, to the fullest extent permitted by Law, be confidential and will only be disseminated to a Representative in order to carry out appropriate activities under this Policy and Procedure.

Confidentiality will also extend to such information that is provided by third parties.
For purposes of this section a "Representative" will mean any individual authorized to preform specific information gathering or disseminating functions for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care.

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

By providing patient care services at Molina, a Provider:

1. Authorizes representatives of Molina to solicit, provide, and act upon information bearing on the 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 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 will 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 will include, but is not limited to:

1. Any type of application or reapplication received by the Provider;
2. Actions reducing, suspending, terminating or revoking a Provider's status, including requests for corrective actions, investigation reports and documents and all other information related to such action;
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 operations and actions relating to Provider conduct.

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

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

Cumulative Effect: The provisions in this Policy and Procedure and any forms relating to authorizations, confidentiality of information, and immunities from liability are in addition to other protections provided by relevant state and federal Law, and are not a limitation thereof.
All Members (voting and non-voting) and guests of the Credentialing Committee, or any other committee performing any peer review functions or other individuals who participate in peer review functions will sign a Statement of Confidentiality annually. Members and guests of the Credentialing Committee will not discuss, share or use any information for any purpose other than peer review at Molina.
The Director in charge of Credentialing grants access to electronic credentials files 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. Each person is given a unique user ID and password. It is the strict policy of Molina that employees keep their passwords confidential and never share their passwords with anyone. All Credentialing employees are prompted to change their passwords into the system every three-months.
Minutes, reports and files of Credentialing Committee meetings are stored in secure electronic folders or in locked cabinets in the Credentialing Department and will be protected from discovery under all applicable Laws.

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

M. Providers Rights during the Credentialing Process

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

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

N. Providers Right to Correct Erroneous Information

Providers have the right to correct erroneous information in their credentials file. Providers 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 Provider immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the Provider. Examples include but are not limited to actions on a license or malpractice claims history. Molina 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 Provider will detail the information in question and will include instructions to the Provider indicating:

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

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

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

O. Providers Right to be Informed of Application Status

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

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

P. Credentialing Committee

Molina designates a Credentialing Committee to make recommendations regarding credentialing decisions using a peer review process. Molina works with the Credentialing Committee to strive to assure that network Providers are competent and qualified to provide continuous quality care to Molina Members. A Provider may not provide care to Molina Members until the credentialing process is complete and the final decision has been rendered.

The Credentialing Committee is responsible for reviewing and evaluating the qualifications of applicant Providers and for making recommendations regarding their participation in the Molina network. In addition, the Credentialing Committee reviews Credentialing Policies and Procedures annually and recommends revisions, additions and/or deletions to the policies and procedures.

Composed of network Providers, the committee is responsible for performing peer review of medical information when requested by the Medical Director, and recommending actions based on peer review findings, if needed. The committees report to the Quality Improvement Committee (QIC).
Each Credentialing Committee Member will be immune, to the fullest extent provided by law, from liability to an applicant or Provider for damages or other relief for any action taken or statements or recommendations made within the scope of the committee duties exercised.

Committee Composition

The Medical Director chairs the Credentialing Committee and appoints all Credentialing Committee Members. Each Member is required to meet all of Molina's credentialing criteria. Credentialing Committee Members must be current representatives of Molina's Provider network. The Credentialing Committee representation includes at least five Providers. These may include providers from the following specialties:

- Dentist
- 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 Providers may be invited to participate when representation of their discipline is needed. Ad hoc committees representing a specific profession (e.g., Behavioral Health Provider, Nurse Practitioners, Chiropractors) may be appointed by the chairs to screen applicants from their respective profession and make credentialing recommendations to the Credentialing Committee.

Committee Members Roles and Responsibilities

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

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

Q. Excluded Practitioner Providers

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

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

R. Ongoing Monitoring of Sanctions

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

Medicare and Medicaid sanctions

The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program releases a report every month of individuals and entities that have been excluded from Medicare and Medicaid programs. Within 30 calendar days of its release, Molina reviews the report and if any Molina Provider is found with a sanction, the Provider'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 Molina Provider is found to be sanctioned/excluded/terminated from any state's Medicaid program, the Provider will be terminated in every state where they are contracted with Molina Healthcare and for every line of business.

Sanctions or limitations on licensure

Molina monitors for sanctions or limitations against licensure between credentialing cycles for all network Providers. All sanction or limitation of license information discovered during the ongoing

monitoring process will be maintained in the Provider credentialing file. All Providers 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 recommendation.

NPDB Continuous Query
Molina -enrolls all network Providers with the National Practitioner Data Bank ("NPDB") Continuous Query service.
Once the Provider is enrolled in the Continuous Query Service, Molina will receive instant notification of all new NPDB reports against the enrolled Providers. When a new report is received between recredentialing cycles, the Provider will be immediately placed into the full credentialing process and will be recredentialed early. The Provider must provide all necessary information to complete the recredentialing process within the requested time-frames or the Provider 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
Each Molina Health Plan has a process in place to investigate Provider-specific complaints from Members upon their receipt. Molina evaluates both the specific complaint and the Provider's history of issues, if applicable. The history of complaints is evaluated for all Providers at least every six months.

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

System for Award Management (SAM)
Molina monitors the SAM once per month to ensure Providers have not been sanctioned. If a Molina Provider is found with a sanction, the Provider's contract is terminated effective the same date the sanction was implemented.

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

S. 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:

1. 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).
2. 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).
3. 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).

T. Office/Facility Site and Medical Record Keeping Practices Review

A review of office sites where you see Molina 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.

Office Visit

At the time of initial credentialing, and every two (2) years Molina Healthcare will perform a site visit of to the office or facility site of primary care practitioners (PCP), obstetricians/, gynecologists (OB/GYN), high volume specialists and high volume behavioral health (BH)) care practitioners.

Facilities

At the time of initial credentialing, and every two 2 years, Molina Healthcare will perform a site visit to facilities that have not been accredited by an approved accrediting body or State Surveyed. These facilities include but are not limited to non-accredited hospitals, home health agencies, skilled nursing facilities, nursing homes, and freestanding surgical centers, BH facilities providing mental health or substance abuse services in the inpatient, residential or ambulatory setting.

Site Review

A standard survey form is completed at the time of each visit. This form includes the 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:

Office:

- Physical accessibility;
- Physical appearance;
- Adequacy of waiting and examining room space;
- Adequacy of medical/treatment record keeping;
- Access requirements; and
- Other miscellaneous office practices (medication management and staffing requirements).

Facilities:

- Physical accessibility;
- Physical appearance;

- Adequacy of waiting and examining room space;
- Adequacy of medical/treatment record keeping;
- Access/Safety;
- Personnel;
- Office Management;
- Clinical Services;
- Preventive Services;
- Infection Control.

Performance Thresholds Requirements

Office:

1. Practitioner sites must demonstrate an eighty percent (80%) compliance threshold with the physical accessibility, appearance, and adequacy of waiting and examining room space criteria. Also, an eighty percent (80%) compliance threshold is required for miscellaneous office site criteria relating to: medication management and staffing requirements.
2. The Molina Healthcare employee will document the site review using the Molina Healthcare Provider Services Practitioner Office Site Review Tool.
3. An office site visit review is conducted at each location in which a Primary Care Practitioner, OB/Gyn or High Volume BH Practitioner see Molina Healthcare Members, as applicable.
4. A site review is not required for practitioners providing care only in patient's homes. A review of medical record keeping practices is required prior to the initial credentialing decision for these practitioners
5. New practitioners who are joining a contracted medical group that has been reviewed and found to meet the eighty percent (80%) threshold with Molina Healthcare site review standards will not require another site review.
6. A practitioner who relocates or opens an additional office site after being initially credentialed must notify Molina Healthcare thirty (30) days prior to the move. When notification is received that a PCP, OB/Gyn, or high volume BH practitioner relocates or opens an additional office, a site review of the new office or location will be scheduled for review

Facilities:

1. Exempted Pass: 90% or above without deficiencies in Critical Elements, Pharmaceutical or Infection Control.
2. Conditional Pass: 80-89%, or 90% and above with deficiencies in either Critical Elements, Pharmaceutical or Infection Control.
3. Not Pass: below 80%.
4. A facility site review is conducted at the site where medical records keeping are maintained.
    - A corrective action plan (CAP) is required for a total score less than 80% or if there are deficiencies in Critical Elements, Pharmaceutical Services or Infection Control. Compliance rates are based on 150 total possible points, or on the total "adjusted" for Not Applicable (N/A) items. "N/A" applies to any scored item that does not apply to a specific site as determined by the reviewer.
    - The Molina Healthcare employee will document the Facility site review using the Molina Healthcare Facility Site Review Survey Tool.

Medical Record Keeping Practice Threshold Requirements

1. Practitioner medical record keeping practices must demonstrate an overall eighty percent (80%) compliance threshold with the Medical Record Keeping Practice Criteria.

2. 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 medical record information in a consistent manner and include how the practice ensures confidentiality of records.
3. Molina Healthcare assesses one medical/treatment record 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.
4. The Molina Healthcare employee will document the review of the medical record using the Molina Healthcare Provider Services Practitioner Office Site Review Tool or on the Facility Site Review Survey Tool if visiting a facility.

Site Visit and Ongoing Monitoring Relating to Member Complaints

1. The Appeals Department continually monitors Member complaints relating to the quality of all provider sites. The Appeals staff will track Member complaints for any type of provider. Complaints to be tracked relating to the quality of an office site includes
   - Physical accessibility;
   - Physical appearance;
   - Adequacy of waiting and examining room space.
2. Molina Healthcare considers the severity of an issue when establishing a reasonable threshold for the number of complaints before conducting an office or facility site visit. When a reasonable complaint threshold of two (2) complaints, relating to the quality of the practitioner's office site or facility, is reached within a twelve (12) month timeframe for any type of practitioner, the Appeals Department will Contact the Credentialing Department to arrange for an unannounced site review to be conducted by a PSR. The Credentialing Department will annotate in the credentialing file the date the Provider Services Department was notified.
3. The unannounced site review is conducted within sixty (60) calendar days of the receipt of the reasonable complaint threshold being met. The Molina Healthcare Provider Services Practitioner Office Site Review Tool is used to document the site visit.
4. Within thirty (30) calendar days of the review, a copy of the site review report and a letter will be sent to the practitioner/facility notifying them of their results.
5. If the office or facility site does not achieve the required threshold for any of the component thresholds or for the over-all threshold, the PSR will do all of the following:
   - Send a letter to the practitioner or facility that identifies the compliance issue(s).
   - Request the practitioner or facility to submit a written corrective action plan (CAP) to Molina Healthcare within thirty (30) calendar days. The request for a CAP will be sent certified mail, return receipt requested. This improvement plan should be submitted by the office manager, facility manager or practitioner and must include the expected time frame for completion of activities.
6. Molina Healthcare will take action to improve the office or facility site and evaluate the effectiveness of its actions at least every six (6) months until the deficient office or facility site meets threshold(s). Molina Healthcare will conduct a follow-up visit of a previously deficient office or facility if the practice site meets the reasonable complaint threshold subsequent to correcting the deficiencies.
7. The information and any response made by the practitioner or facility is included in the practitioners or facilities permanent credentials file and reported to the PRC. If compliance is not attained at follow-up visits, an updated CAP will be required.
8. Practitioners or facility who does not submit a CAP may be terminated from network participation. Any further action is conducted in accordance with the Molina Healthcare Credentialing and Fair Hearing Policies and Procedures.

9. If another complaint directed at the same office or facility site is received, Molina Healthcare is not required to perform another site visit; only to follow up on that specific complaint. However, if Molina Healthcare receives another compliant of the same office or facility, but for a different criterion, a site visit will be performed, but only on the specific office site criteria pertaining to that complaint.
10. To document the site visits and ongoing monitoring process, the PSR will forward results to the credentialing specialist and the results will be annotated in a note in the credentialing file to include :
    - Notification date from Appeals Department;
    - Date Credentialing Department notifies Provider Services Department; and Date Provider Services completes onsite visit with final scores.
11. If during a PSR routine provider visit, any problems with the quality of an office or facility site are discovered, the PSR will immediately notify the Appeals Department for tracking of the issue
12. If the complaint is received regarding a delegated credentialed provider, a site review will be conducted by a staff member from the delegated entity.

Improvement Plans/Corrective Action Plans

1. Within thirty (30) calendar days of the office or facility site visit, a letter will be sent notifying the site of their results.
2. The office or facility site visit must meet threshold requirements.
3. If the office or facility site does not achieve the required compliance thresholds, the PSR or QI Representative will do all of the following:
    - Send a letter to the practitioner or facility site manager that identifies the compliance issues and request that a written corrective action plan (CAP) be submitted to Molina Healthcare within thirty (30) calendar days of notification. The request for a CAP will be sent certified mail, return receipt requested. This improvement plan should be submitted by the office manager, facility manager or practitioner and must include the expected time frame for completion of activities;
    - Send sample forms and other information to assist the practitioner or facility manager to achieve a passing score on the next review;
    - Send notification that another review will be conducted of the office or facility within sixty (60) calendar days of the initial site visit.
4. The PSR must conduct the follow-up site visit within sixty (60) calendar days of the initial site visit. Office or facility sites re-audited and not achieving threshold score will be presented to PRC with a recommendation from Credentialing to terminate. The practitioners or facility manager will be notified in writing of all actions taken by the committee regarding the site visit within fifteen (15) calendar days of the committee action.

Any further disciplinary action is conducted in accordance with the Molina Healthcare Credentialing and Fair Hearing Policy and Procedures.

U. Range of Actions, Notification to Authorities and Provider Appeal Rights

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

Range of actions available

The Molina Credentialing Committee can take one of the following actions against Providers 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 Provider 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 Providers who are contracted by Molina. 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 Provider 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 Provider may be given the opportunity to appeal this decision.

Criteria for Denial or Termination Decisions by the Credentialing Committee

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

1. The Provider's professional license in any state has or has ever had any informal or formal disciplinary orders, decisions, agreements, disciplinary actions or other actions including but not limited to, restrictions, probations, limitations, conditions suspensions and revocations.
2. Provider has or has ever surrendered, voluntarily or involuntarily, his or her professional license in any State while under investigation by the State or due to findings by the State resulting from the Provider's acts, omissions or conduct.
3. Provider has any pending statement of charges, notice of proposed disciplinary actions, notice of agency action or the equivalent from any state or governmental professional disciplinary body which based on the judgment of the Credentialing Committee establishes an immediate potential risk to the quality of care or service delivered by the Provider to Molina members.
4. Provider 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. Provider has a condition, restriction or limitation on their license, certification or registration related to an alcohol, chemical dependency, or health condition or if other evidence indicates that the Provider has an alcohol, chemical dependency problem or health condition and there is no clear evidence and documentation demonstrating that the Provider has complied with all such conditions, limitations, or restrictions and is receiving treatment adequate to ensure that the alcohol, chemical dependency problem or health condition will not affect the quality of the Provider's practice.
6. Provider has or has ever had sanctions of any nature taken by any Governmental Program or professional body including but not limited to, Medicare, Medicaid, Federal Employee Program or any other State or Federal program or agency.
7. Provider 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. Provider's history of medical malpractice claims or professional liability claims or settlements reflect what constitutes a pattern of questionable or inadequate treatment or contain what constitutes any gross or flagrant incident or incidents of malpractice.
9. Provider has a criminal history, including, but not limited to, any criminal charges, criminal investigations, convictions, no-contest pleas and guilty pleas.
10. Provider has or has ever had involvement in acts of dishonesty, fraud, deceit or misrepresentation that relate to or impact or could relate to or impact the Provider's professional conduct or the health, safety or welfare of Molina Members.
11. Provider has or has ever engaged in acts which Molina, in its sole discretion, deems inappropriate.
12. Provider has or has ever had a pattern of Member complaints or grievances in which there appears to be a concern regarding the quality of service provided to Molina Members.
13. Provider has not complied with Molina's quality assurance program.
14. Provider is found to have rendered a pattern of substandard care or is responsible for any gross or flagrant incident of substandard care.
15. Provider has or has ever displayed inappropriate patterns of referral, which deviate substantially from reasonably expected patterns of referral.
16. Provider makes or has ever made any material misstatements in or omissions from their credentialing application and attachments.
17. Provider has ever rendered services outside the scope of their license.
18. Provider has or has ever had a physical or mental health condition that may impair their ability to practice with the full scope of licensure and qualifications, or might pose a risk of harm on patients.
19. Provider has or has ever failed to comply with the Molina Medical Record Review Guidelines.
20. Provider has or has ever failed to comply with the Molina Site Review or Medical Record Keeping Practice Review Guidelines.

Monitoring on a Committee Watch Status

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

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

Corrective Action

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

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 Provider on a corrective action plan, the Provider will be notified via a certified letter from the Medical Director. Such notification will outline:

- The reason for the corrective action
- The corrective action plan

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

Summary Suspension

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

Such summary suspension will become effective immediately upon imposition, and the Medical Director will promptly notify the Provider of the suspension by written notification sent via certified letter. Notification will include the following:

- A description of the action being taken.
- Effective date of the action.
- The reason(s) for the action and/or information being investigated.
- Information (if any) required from the Provider.
- The length of the suspension.
- The estimated timeline for determining whether or not to reinstate or terminate the Provider.
- Details regarding the Providers 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 Provider 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 Provider's continued participation, discontinue the suspension or terminate the Provider.

Denial

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

The Provider 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 Provider is sent a written notice of denial via certified mail, from the Medical Director, which includes the reason for the denial.

Termination

After review of appropriate information, the Credentialing Committee may determine that the Provider 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 Provider.

Terminations for reasons other than unprofessional conduct or quality of care

If the termination is based on reasons other than unprofessional conduct or quality of care, the Provider 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 Provider 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

If the termination is based on unprofessional conduct or quality of care, the Provider will be given the right to a fair hearing. Within ten (10) calendar days of the Committee's decision, the Provider is sent a written notice of Molina'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 Provider'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 will appoint a hearing officer and a panel of individuals to review the appeal.
- The Provider 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.
- Provider's right to be represented by an attorney or another person of their choice.
- Obligations of the Provider regarding further care of Molina Patients/Members.
- The action will be reported to the NPDB and the State Licensing Board.

Molina will wait 30 calendar days from the date the terminated Provider received the notice of termination. If the Provider requests a fair hearing within that required timeframe, Molina will follow the Fair Hearing Plan Policy. Once the hearing process is completed, the Provider 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 Provider remains in the Molina network, the action will not be reportable to the State Licensing Board or to the NPDB.

If the Provider 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 Provider 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

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

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

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

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

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

V. Fair Hearing Plan Policy

Under State and Federal Law, certain procedural rights will be granted to a Provider in the event that peer review recommendations and actions require a report be made to the State Licensing Board and the National Practitioner Data Bank (NPDB). Molina Healthcare, Inc., and its Affiliates ("Molina"), will maintain and communicate the process providing procedural rights to Providers when a final action by Molina will result in a report to the State Licensing Board and the NPDB.

Definitions

1. Adverse Action will mean an action that entitles a Provider to a hearing, as set forth in Section B (l)-(3) below.
2. Chief Medical Officer will mean the Chief Medical Officer for the respective Molina Affiliate state plan wherein the Provider is contracted.
3. Days will 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 will not be included.
4. Medical Director will mean the Medical Director for the respective Molina Affiliate state plan wherein the Provider is contracted.
5. Molina Plan will mean the respective Molina Affiliate state plan wherein the Provider is contracted.
6. Notice will mean written notification sent by certified mail, return receipt requested, or personal delivery.
7. Peer Review Committee or Credentialing Committee will mean a Molina Plan committee or the designee of such a committee.
8. Plan President will mean the Plan President for the respective Molina Affiliate state plan wherein the Provider is contracted.
9. Provider will mean physicians, dentists, and other health care Practitioners as defined by 42 USC 11151 and Social Security Act § 1861(u).
10. State will mean the licensing board in the state in which the Provider practices.

11. State Licensing Board will mean the state agency responsible for the licensure of Provider.
12. Unprofessional Conduct refers to a basis for corrective action or termination involving an aspect of a Provider's competence or professional conduct which is reasonably likely to be detrimental to patient safety or the delivery of quality care. Unprofessional conduct does not refer to instances where a Provider violates a material term of the Provider's contract with a Molina Plan.

Grounds for a Hearing

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

1. Revocation, termination of, or expulsion from Molina Provider status when such revocation, termination, or expulsion is reportable to the State Licensing Board and the NPDB.
2. Suspension, reduction, limitation, or revocation of authority to provide care to Molina Members when such suspension, reduction, limitation, or revocation is reportable to the State Licensing Board and the NPDB.
3. Any other final action by Molina that by its nature is reportable to the State Licensing Board and the NPDB.

Notice of Action

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

1. State the reasons for the action;
2. State any Credentialing Policy provisions that have been violated;
3. Advise the Provider that he/she has the right to request a hearing on the proposed Adverse Action;
4. Advise the Provider that any request for hearing must be made in writing within thirty (30) days following receipt of the Notice of Action, and must be sent to the respective Molina Plan Medical Director by certified mail, return receipt requested, or personal delivery;
5. Advise the Provider that he/she has the right to be represented by an attorney or another person of their choice.
6. Advise the Provider that the request for a hearing ***must*** be accompanied by a check in the amount of $1,000.00 as a deposit for the administrative expenses of the hearing and specify that this amount will be refunded if the Adverse Action is overturned;
7. State that the proposed action or recommendation, if adopted, must be reported pursuant to State and Federal Law; and
8. Provide a summary of the Provider's hearing rights or attach a copy of this Policy.

Request for a Hearing - Waiver

If the Provider does not request a hearing in writing to the Chief Medical Officer within thirty (30) days following receipt of the Notice of Action, the Provider will be deemed to have accepted the action or recommendation of the Peer Review Committee and/or Credentialing Committee, and such action or recommendation will 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 will be appointed as set forth below and the Peer Review Committee and/or Credentialing Committee will 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 will 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

1. Composition of Hearing Committee
   The Chief Medical Officer/Plan President will select the individuals to serve on the Hearing Committee. The Hearing Committee will consist of individuals who are not in direct economic competition with the subject Provider; who will gain no direct financial benefit from the outcome of the hearing; and, who will 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 will not preclude a physician from serving as a Member of the panel.

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

2. Scope of Authority
   The Hearing Committee will have the authority to interpret and apply this Policy insofar as it relates to its powers and duties.
3. Responsibilities
   The Hearing Committee will:
   a. Evaluate evidence and testimony presented.
   b. Issue a decision accepting, rejecting, or modifying the decision of the Peer Review Committee and/or Credentialing Committee.
   c. Maintain the privacy of the hearing unless the Law provides to the contrary.
4. Vacancies
   In the event of a vacancy in a hearing panel after a hearing has commenced, the remaining panel members may continue with the hearing and determination of the controversy, unless the parties agree otherwise.
5. Disclosure and Challenge Procedures
   Any person appointed to the Hearing Committee will disclose to the Chief Medical Officer/Plan President any circumstance likely to affect impartiality, including any bias or a financial or personal interest in the result of the hearing or any past or present relationship with the parties or their representatives. The Hearing Officer may remove any person appointed to the Hearing Committee if the Hearing Officer believes that the person is unable to render an impartial decision.

Hearing Officer

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

2. Scope of Authority
   The Hearing Officer will have the sole discretion and authority to:
   a. Exclude any witness, other than a party or other essential person.
   b. Determine the attendance of any person other than the parties and their counsel and representatives.
   c. For good cause shown to postpone any hearing upon the request of a party or upon a Hearing Committee's own initiative, and will also grant such postponement when all of the parties agree thereto.
3. Responsibilities
   The Hearing Officer will:
   a. Guide the hearing process, including endeavoring to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner;
   b. Ensure that proper decorum is maintained;
   c. Be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing;
   d. Issue rulings pertaining to matters of Law, procedure and the admissibility of evidence;
   e. Issue rulings on any objections or evidentiary matters;
   f. Discretion to limit the amount of time;
   g. Assure that each witness is sworn in by the court reporter;
   h. May ask questions of the witnesses (but must remain neutral/impartial);
   i. May meet in private with the panel members to discuss the conduct of the hearing;
   j. Remind all witnesses at the conclusion of their testimony of the confidentiality of the hearing;
   k. Participate in the deliberations of the Hearing Committee as a legal advisor, but will not be entitled to vote; and
   l. Prepare the written report.

Time and Place of Hearing

Upon receipt of a Request for Hearing, the Chief Medical Officer and/or Plan President will schedule and arrange for a hearing. The Chief Medical Officer and/or Plan President will 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 will 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 will set the date, time, and location for additional meetings.

Notice of Hearing

The Notice of Hearing will contain and provide the affected Provider with the following:

1. The date, time and location of the hearing.
2. The name of the Hearing Officer.
3. The names of the Hearing Committee Members.
4. A concise statement of the affected Provider's alleged acts or omissions giving rise to the Adverse Action or recommendation, and any other reasons or subject matter forming the basis for the Adverse Action or recommendation which is the subject of the hearing.
5. The names of witnesses, so far as they are then reasonably known or anticipated, who are expected to testify on behalf of the Peer Review Committee and/or Credentialing Committee, provided the list may be updated as necessary and appropriate, but not later than ten (10) days prior to the commencement of the hearing.

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

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

Pre-Hearing Procedures

1. The Provider will have the following pre-hearing rights:
   a. To inspect and copy, at the Provider's expense, documents upon which the charges are based which the Peer Review Committee and/or Credentialing Committee have in its possession or under its control; and
   b. To receive, at least thirty (30) days prior to the hearing, a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the Provider to prepare a defense, including all evidence that was considered by the Peer Review Committee and/or Credentialing Committee in recommending Adverse Action.
2. The Hearing Committee will have the following pre-hearing right:
   To inspect and copy, at Molina's expense, any documents or other evidence relevant to the charges which the Provider has in his or her possession or control as soon as practicable after receiving the hearing request.
3. The Hearing Officer will 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 will consider:
   a. Whether the information sought may be introduced to support or defend the charges;
   b. The exculpatory or inculpatory nature of the information sought, if any;
   c. The burden attendant upon the party in possession of the information sought if access is granted; and
   d. Any previous requests for access to information submitted or resisted by the parties.
4. The Provider will 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 will be ruled on by the Hearing Officer.
5. It will be the duty of the Provider, the Peer Review Committee and/or Credentialing Committee to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.
6. Failure to disclose the identity of a witness or produce copies of all documents expected to be produced at least ten (10) days before the commencement of the hearing will constitute good cause for a continuance or limitation of the evidence or the testimony if deemed appropriate by the Hearing Officer.
7. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable physicians or patients, other than the Provider under review, or to information, interviews, reports, statements, findings and conclusions resulting from studies or other data prepared specifically to be submitted for review purposes made privileged by operation of State.

Conduct of Hearing

1. Rights of the Parties

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

   a. Call and examine witnesses for relevant testimony.
   b. Introduce relevant exhibits or other documents.
   c. Cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues.
   d. Otherwise rebut evidence.
   e. Have a record made of the proceedings.
   f. Submit a written statement at the close of the hearing.
   g. Receive the written recommendation of the Hearing Officer or Hearing Committee, including a statement of the basis for the recommendations, upon completion of the hearing.

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

2. Course of the Hearing
   a. Each party may make an oral opening statement.
   b. The Peer Review Committee and/or Credentialing Committee will call any witnesses and present relevant documentary evidence to support its recommendation.
   c. The affected Provider may then call any witnesses and present relevant documentary evidence supporting his/her defense.
   d. The Hearing Committee or Officer has the discretion to vary the course of the hearing, but will afford a full and equal opportunity to all parties for the presentation of material and relevant evidence and for the calling of witnesses.
   e. The Hearing Committee will be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence will not be necessary. All evidence will be taken in the presence of the entire Hearing Committee and all of the parties, except when agreed to by the parties, or determined by the Hearing Officer.
3. Use of Exhibits
   a. Exhibits, when offered by either party, may be received into evidence by the Hearing Committee as ruled upon by the Hearing Officer.
   b. A description of the exhibits in the order received will be made a part of the record.
4. Witnesses
   a. Witnesses for each party will submit to questions or other examination.
   b. The Hearing Officer will 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 will be made a part of the record.
   c. The Hearing Committee may receive and consider the evidence of witnesses by affidavit, but will give it only such weight as the Hearing Committee deems it is entitled to after consideration of any objection made to its admission.
   d. The party producing such witnesses will pay the expenses of their witnesses.
5. Rules for Hearing:
   a. Attendance at Hearings

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

b. Communication with Hearing Committee
   There will 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 will be directed to the Hearing Officer for transmittal to the Hearing Committee.
c. Interpreter
   Any party wishing to utilize an interpreter will make all arrangements directly with the interpreter and will assume the costs of the services.

Close of the Hearing
At the conclusion of the hearing, the Hearing Officer will dismiss all parties and participate in the deliberations of the Hearing Committee. The Hearing Committee will 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 will issue a written report including the following:
1. A summary of facts and circumstances giving rise to the hearing.
2. A description of the hearing, including:
   a. The panel members' names and specialties;
   b. The Hearing officer's name;
   c. The date of the hearing;
   d. The charges at issue; and
   e. An overview of witnesses heard and evidence.
3. The findings and recommendations of the Hearing Committee.
4. Any dissenting opinions desired to be expressed by the hearing panel members.

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

Burden of Proof
In all hearings it will 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 will come forward with evidence in his/her support.

The burden of proof during a hearing will be as follows:
The Peer Review Committee or Credentialing Committee taking or recommending the Adverse Action will 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
Failure, without good cause, of the Provider to personally attend and proceed at a hearing in an efficient and orderly manner will be deemed to constitute voluntary acceptance of the recommendations or actions involved.

Record of the Hearing/Oath
A court reporter will 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 will be borne by Molina, but the cost of the transcript, if any, will be borne by the party requesting it. The Hearing Officer will be required to order that all oral evidence be taken by oath administered by a person lawfully authorized to administer such oath.

Representation
Each party will 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.

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

Notification of Finding
The Hearing Office will 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
Upon receipt of the Hearing Committee's decision, the Chief Medical Officer/Plan President will either adopt or reject the Hearing Committee's decision. The Chief Medical Officer/Plan President's action constitutes the final decision.

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

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

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

Although an external hearing process does not exist for a Provider, any Provider who is dissatisfied with the result of a Complaint, Appeal or fair hearing review decision may contact the Superintendent of Insurance at the address below.

Office of the Superintendent of Insurance
Attn: Managed Health Care Bureau
New Mexico Public Regulation Commission
P.O. Box 1269
1120 Paseo de Peralta Santa Fe, NM 87504-1269

Santa Fe: (505) 827-4428
Fax: (505) 837-4734
Email: mhcb.grievance@state.nm.us

Confidentiality and Immunity

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

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

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

By providing patient care services at Molina, a Provider:

1. Authorizes representatives of Molina to solicit, provide, and act upon information bearing on the 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 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 will 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 will include, but is not limited to:

1. Any type of application or reapplication received by the Provider;
2. Actions reducing, suspending, terminating or revoking a Provider's status, including requests for corrective actions, investigation reports and documents and all other information related to such action;
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 operations and actions relating to Provider conduct.

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

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

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

W. Health Delivery Organizations (HDO)

Molina Healthcare is committed to providing quality care and services to its members. To help support this goal, Molina Healthcare completes an assessment of organizational providers with whom it contracts. In addition, Molina Healthcare completes a reassessment of all contracted organizational providers every thirty-six (36) months. Organizational providers are required to meet established criteria. Molina Healthcare does not contract with organizational providers that do not meet the criteria.

The decision to accept or deny an organizational provider is based upon primary source verification, secondary source verification 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.

Type of Organizational Providers Assessed

The organizational provider types assessed may include but are not limited to the following:

Agencies

Case Management Agency
Day Training, Developmentally Disabled Services Agency
Early Intervention Provider Agency
Home Health Agency
Hospice Care Agency
In Home Supportive Care Agency
Nursing Care Agency
Program for All- Inclusive Care for the Elderly (PACE) Provider Organization
Public Health Agency
Supports Brokerage

Ambulatory Health Care Facilities

Adolescent & Children Mental Health Center
Adult Day Care Center
Adult Mental Health
Ambulatory Family Planning Facility
Ambulatory Surgical Center
Amputee Center
Augmentative Communication Center
Birthing Center
Critical Access Hospital
Emergency Care Center
Endoscopy Center
End-Stage Renal Disease (ESRD) Treatment Center
Federally Qualified Health Center (FQHC)

Infusion Therapy Clinic
Lithotripsy Center
Magnetic Resonance Imaging Center (MRI)
Medically Fragile Infants and Children Day Care Center
Mental Health Center
Occupational Therapy Center
Oncology, Radiation Center
Ophthalmologic Surgery Center
Oral and Maxillofacial Surgery Center
Physical Therapy Center
Radiology Center
Radiology Center, Mammography
Rehabilitation Center, Substance Use Disorder
Rural Health Clinic (RHC)
Speech Therapy Center
Urgent Care Center

Hospitals

Chronic Disease Hospital
Chronic Disease Hospital – Children
General Acute Care Hospital
General Acute Care Hospital – Children
General Acute Care Hospital – Critical Access
General Acute Care Hospital – Rural
General Acute Care Hospital – Women
Long Term Care Hospital
Psychiatric Hospital
Rehabilitation Hospital
Rehabilitation Hospital – Children
Religious Nonmedical Health Care Institution
Special Hospital

Laboratories

Clinical Medical Laboratories
Dental Laboratories
Physiological Laboratory

Nursing and Custodial Care Facilities

Assisted Living Facility
Assisted Living, Behavioral Disturbances
Assisted Living, Mental Illness
Custodial Care Facility
Adult Care Home
Hospice Inpatient
Intermediate Care Facility, Mental Illness
Intermediate Care Facility, Mental Retarded
Nursing Facility / Intermediate Care Facility
Skilled Nursing Facility
Skilled Nursing Facility, Nursing Care, Pediatric

Residential Treatment Facilities

Community Based Residential Treatment Facility, Mental Illness
Community Based Residential Treatment Facility, Mental Retardation and/or developmental Disabilities
Psychiatric Residential Treatment Facility
Residential Treatment Facility, Emotionally Disturbed Children
Residential Treatment Facility, Mental Retardation and/or developmental Disabilities
Residential Treatment Facility, Physical Disabilities
Substance Abuse Rehabilitation Facility
Substance Abuse Rehabilitation Facility, Children

Respite Care Facilities

Respite Care
Respite Care Facility, Camp
Respite Care Facility, Mental Illness, Child
Respite Care Facility, Mental Retardation and/or Developmental Disabilities
Respite Care Facility, Physical Disabilities, Child

Suppliers

Blood Bank
Durable Medical Equipment & Medical Supplies
DME - Customized Equipment
DME - Dialysis Equipment & Supplies
DME - Nursing Facility Supplies
DME - Oxygen Equipment & Supplies
DME - Parental & Enteral Nutrition
Emergency Response System Companies
Eye bank
Eyewear Supplier
Hearing Aid Equipment
Home Delivered Meals
Medical Food Supplier
Organ Procurement Organization
Portable X-ray Supplier
Prosthetic/Orthotic Supplier

Transportation Services

Ambulance
Ambulance – air transportation
Ambulance – land transportation
Ambulance – water transportation
Bus
Non-Emergency Medical Transport (VAN)
Secured Medical Transport (VAN)
Transportation Broker

Other Atypical Providers

Home/environment modification
Pest Control
Homemaker Services
Personal Care Services
Community Health Workers
Community Transition Services (Housing)

Adaptive Assistance Devices
Financial Assessment/Risk Reduction Services
Core Services Agencies
Employment Support
Nutritional Consultation
Independent Living Assistance

Atypical providers do not provide health care. This is further defined under HIPAA in Federal regulations at 45 CFR 160.103. Taxi services, home and vehicle modifications, and respite services are examples of atypical providers reimbursed by the Medicaid program. Even if these atypical providers submit HIPAA transactions, they still do not meet the HIPAA definition of health care and do not receive an NPI number. Therefore, atypical providers will not have a Taxonomy code.

Approved accrediting agencies

Approved accrediting agencies accepted by Molina Healthcare are any accrediting agencies that have been deemed by CMS. These include but are not limited to the following:

- The Joint Commission (TJC)
- American Osteopathic Association (AOA)
- National Committee for Quality Assurance (NCQA)
- Commission for Accreditation of Rehabilitation Facilities (CARF)
- Accreditation Association for Ambulatory Health Care (AAAHC)
- American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF)
- The Commission for the Accreditation of Birth Centers (CABC)
- Community Health Accreditation Program (CHAP)
- The Accreditation Commission for Health Care, Inc. (ACHC)
- The Council on Accreditation (COA)
- American Society of Histocompatibility and Immunogenetics (ASHI)
- College of American Pathologists (CAP)
- Commission on Laboratory Accreditation (COLA)
- American Association of Blood Banks (AABB)
- DNV Healthcare Inc. (DNVHC)

Criteria for Participation in the Molina Network

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

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

Organizational providers must meet the following criteria to be eligible to participate in the

Molina Healthcare network. If the organizational provider fails to provide proof of meeting these criteria, the application will be deemed incomplete and it will result in an administrative denial or termination from the Molina Healthcare network. Organizational providers that have been denied initial network participation by the Credentialing Committee are not eligible to reapply for participation until one year after the date of denial. Organizational Providers terminated by the Credentialing Committee or terminated from the network for cause are not eligible to reapply until five years after the date of terminations.

- Organizational provider must submit a complete, signed and dated application and all requested documentation. Application must be typewritten or completed in non-erasable ink. The attestation must be within 180-calendar days old at the time of decision. All reassessment information must be submitted by the organizational provider within the timeframe requested.
- Organizational Provider must have a current, valid license, certification or registration to operate in their specialty area(s) in every state in which they will provide care and/or services for Molina Healthcare members.
- If the organizational provider does not have a facility license, certification or registration, they must provide a list of all employed individually licensed practitioners and their license numbers. Each practitioner must have a current, valid license, certification or registration to practice in their specialty in every state in which they will provide care and/or services for Molina members.
- The organizational provider must attest on the application that they verify all of their employees:
    1. Are licensed in good standing in the states in which they will be seeing Molina Healthcare members (if providing health care services);
    2. Do not have OIG and/or SAM sanctions; and
    3. Have had a criminal background check completed and have never been convicted of a felony or pled guilty to a felony for a health-care related crime, including but not limited to health care fraud, patient abuse and the unlawful manufacture, distribution, prescription, or dispensing of controlled substance.
- At the time of initial application, the organizational provider's state license(s), certification(s) and or registration(s) must be currently free of any restrictions, limitations, conditions or sanctions (formal or informal) and there should be no such open or pending investigations. The organizational provider also must not have any of the following sanctions imposed by Medicare, Medicaid, accrediting agencies or other state and federal agencies:
    1. Stop placement status;
    2. Denial of payment status;
    3. Temporary management status;
    4. Pending state charges, actions;
    5. Excluded or expelled status; and
    6. Loss of accreditation, licensure or certification status.
- Organizational provider must meet at least one of the following requirements:
    1. Be accredited through an accrediting agency that has approval from the Centers for Medicare and Medicaid (CMS) services for deeming authority of accreditation.

2. Non-accredited organizational providers must be approved and have passed inspection by CMS or the applicable state agency. The CMS or state survey may not be greater than three years old at the time of verification.
3. Molina Healthcare conducts an onsite quality assessment if the organizational provider does not meet one of the two previously listed criteria under a or b. (Exception – Molina Healthcare does not conduct site visits for non-accredited organizational providers when the state or CMS has not conducted a site review when the provider is in a rural area as defined by the U.S. Census Bureau)

- Evidence that the organizational provider has been approved for Medicare participation or is certified by the appropriate agency for provision of applicable services.
- Organizational provider must have current professional malpractice liability coverage and general liability insurance coverage with limits that meet Molina criteria specifically outlined in this policy. The insurance must be through a commercial carrier or statutory authority.
- If applicable to the organizational provider type, provider must have a current and unrestricted federal Drug Enforcement Agency (DEA) certificate.
- Birthing Centers must submit a clear written plan of transfer and transition of patients in emergent situations. The plan must include the name(s) of the hospital and the name(s) of the OB/GYN or Physician providing back up.
- Hospitals and Laboratories and all other organizational providers conducting laboratory testing must have a current CLIA in good standing.

Ownership and/or Controlling Interest in the Organizational Provider

The organizational provider, person(s) with ownership or controlled interest in the organizational provider and managing employees of the organizational provider must not have ever been:

1. Convicted of a felony or pled guilty to a felony for a health-care related crime, including but not limited to health care fraud, patient abuse and the unlawful manufacture, distribution, prescription, or dispensing of controlled substance.
2. Excluded, expelled or suspended from any federally funded programs, including but not limited to, the Medicare or Medicaid programs.
3. Excluded, expelled or suspended from any state funded programs including but not limited to Medicare or Medicaid.

Section 12 – Provider Responsibility / Participation Requirements

Prior to contracting with Molina Healthcare, providers must be enrolled with New Mexico Medicaid. All providers with a National Provider Identifier (NPI) that is not associated with an active New Mexico Medicaid Fee-For-Service or Managed Care Provider record (status 60 or 70) in the Omnicaid system and has or will provide health care services are required to enroll with the New Mexico Medical Assistance Division (MAD) Medicaid Program or their claims will be denied.

A. Critical Incident Reporting

Providers delivering Home and Community Based Services (HCBS) are responsible for Incident Management. All providers rendering Centennial Care funded services to the Home and Community Based Services (HCBS) population are required to report critical incidents and to develop and implement an incident management system that at minimum maintains, tracks, and trends data from the reports and includes the data in quality assurance activities.

Community agencies providing Medicaid Home and Community Based services (HCBS) are required to report critical incidents to the State Human Services Division (HSD) using their online Critical Incident Reporting portal (https://criticalincident.hsd.state.nm.us). HCSBS includes, but are not limited to, Personal Care services, Self-Directed Benefit services, Behavioral Health services, and Home Health services.

All allegations of Abuse, Neglect, and Exploitation of a Member must be reported, as well as any incidents involving Emergency Services, Hospitalization, the Death of a Member the involvement of Law Enforcement, any Environmental Hazards that compromise the health and safety of a Member, and any Elopement of Missing Member.

Agencies that do not comply with the incident reporting requirements are in violation of state statues and federal regulations, and may be sanctioned up to and including termination of their Provider Agreement with Molina or by the HSD Medical Assistance Division.

Providers are expected to cooperate with any investigation conducted by the Molina Healthcare Quality Improvement Department by providing additional information as requested. Request for additional information may include: root cause analysis, documentation from internal investigations, policies and procedures, site visits, chart reviews and staff/Member interviews. Some investigations may be part of a collaboration with HSD he Behavioral Health Collaborative, New Mexico Department of Health, (Child Protective Services and Adult Protective Services.

For more information about critical incident reporting requirements, contact the Quality Improvement Department toll free at: **(800) 377-9594, ext. 180343.**If you have questions regarding these requirements, please contact Provider Services toll free at (800) 377-9594.

B. Primary Care Practitioner (PCP) Responsibilities

The Centennial Care PCP is a medical or behavioral health practitioner responsible for supervising, coordinating, and providing primary health care to Member's initiating referrals for specialist care, and maintaining the continuity of the Member's care.

The PCP's responsibilities as the manager of Member's care are as follows:

1. The PCP provides all the Member's primary care health services. PCPs are responsible for twenty-four (24) hour, seven (7) day-a-week coverage. Members are instructed to contact their PCP prior to seeking care in all cases except life threatening emergencies. Members who require care for a life-threatening emergency are instructed to notify their PCP within twenty-four (24) hours of emergency treatment. A family Member may make this notification. If electronic answering machines are used, messages should include the following: 1) Name and telephone number of the on-call practitioner, with instructions to contact that practitioner; and 2) A disclaimer that if the Member presents to the emergency room or urgent care facility without contacting the on-call practitioner, payment by Molina Healthcare can be denied.
2. When specialized care is needed, the PCP will provide a referral to a participating specialist. The PCP should ensure the information from the specialty practitioner is reviewed and included in the Member's medical record within ninety (90) days after the conclusion of treatment. If the Member requires care which can only be provided outside of Molina Healthcare's provider panel, the PCP will work with Molina Healthcare and/or Medical Director to arrange for the appropriate services;
3. Upon request, the PCP is required to provide the Member information about the PCP's education, training, applicable certification, and any subspecialty;
4. All lab and imaging services ordered by the PCP must be performed either in the PCP's office, the office of a participating practitioner/provider or laboratory, or at one of the participating hospitals or outpatient centers;
5. All elective hospital inpatient, residential treatment, skilled nursing facility, and home health care admissions must be approved in advance by the PCP or the admitting practitioner (if a referral has been made by the PCP). The PCP or admitting practitioner must coordinate care with hospitals that require in-house staff to examine or treat Members. The PCP, specialist and hospitalist caring for a Member with special health care needs should contact Molina Healthcare to assist in coordination of care with the assigned Care Coordinator;
6. Use outpatient surgical services whenever medically appropriate;
7. Advise the Member of advance directive processes available. The Member can obtain forms by calling our Member Service Department;
8. The PCP maintains Member medical records in accordance with the standards established by Molina Healthcare. Molina Healthcare's standards are outlined in this section; and
9. The PCP is responsible for the education and training of all individuals working with his/her medical practice to assure that the procedures for Molina Healthcare's managed care delivery system are followed correctly. Representatives of the Provider Services Department are available to provide staff training which may include referral, grievance and billing procedures.

PCPs, BH practitioners, and other practitioners/providers should play an active role in the Member's BH treatment. One of the most important things to remember is that the

Member and his/her family must be a part of the treatment planning process.

The role of the PCP is to refer the Member to the appropriate level of behavioral health care. A referral is not needed for a Molina Healthcare Member to access behavioral health care. The PCP should assist the Member in accessing needed behavioral health services. The PCP will refer a Member for behavioral Health Services based upon the following indicators:

- Suicidal/homicidal ideation or behavior;
- At-risk of hospitalization due to a BH condition;
- Children or adolescents at imminent risk of out-of-home placement in a psychiatric acute care hospital or residential treatment facility;
- Trauma victims;
- Serious threat of physical or sexual abuse of risk to life or health due to impaired mental status and judgment, mental retardation, or other developmental disabilities;
- Request by Member or Representative for BH services;
- Clinical status that suggests need for BH services;
- Identified psychosocial stressors and precipitants;
- Treatment compliance complicated by behavioral characteristics;
- Behavioral and psychiatric factors influencing medical conditions;
- Victims or perpetrators of abuse and/or neglect and Members suspected of being subject to abuse and/or neglect;
- Non-medical management of substance abuse;
- Follow-up to medical detoxification;
- An initial PCP contact or routine physical exam indicates a substance abuse problem;
- A prenatal visit indicates substance abuse problems;
- Positive response to questions indicates substance abuse, observation of clinical indicators or laboratory values that indicate substance abuse;
- A pattern of inappropriate use of medical, surgical, trauma, or emergency room services that could be related to substance abuse or other BH conditions; and/or
- The persistence of serious functional impairment.

C. Specialist as PCP

A Member may select a board-certified specialist as PCP if clinically appropriate and if the specialist agrees to provide PCP services. Members are advised in the Member Handbook that, if appropriate, they may use a Specialist as a PCP based on a special health care need. Board-certified physicians from appropriate specialty areas function as PCPs.

Board-certified psychiatrists are the only behavioral health practitioners who qualify and may serve as PCPs.

D. Specialty Provider Responsibilities

When the PCP determines that a Molina Healthcare Member needs to see a specialist, the PCP initiates a referral. It is important for specialty practitioners/providers to advise the PCP when follow-up care is necessary. The specialty practitioner may treat as necessary within the parameters of the referral from the PCP that is appropriate (i.e. lab tests, radiology, therapies, etc.). If the Member requires a procedure for which prior authorization is required, including hospitalization, the specialty practitioner is responsible for obtaining

the proper authorization from Molina Healthcare.

Specialty practitioners will ensure that services provided are documented and incorporated into the Member's primary care medical record within ninety (90) days after the conclusion of treatment. The specialty practitioner will be responsible for the education and training of all individuals working within his/her medical practice to assure that Molina Healthcare's procedures are followed correctly. Upon request, the specialty practitioner is required to provide the Member with information about the specialty practitioner's/provider's education, training, applicable certification, and any subspecialty.

The specialty practitioner will advise the Member of advance directive processes available. Members may obtain forms by calling the Member Service Department.

Under certain circumstances, and with prior approval, a specialist can act as the Member's PCP for some chronic or long term care conditions. Call the Provider Services Department for more information.

E. General Provider Responsibilities

1. Abuse and/or Neglect Reporting

Every person who knows or has reasonable suspicion that a child or adult is being abused or neglected in New Mexico must report the matter immediately. Specific professionals mentioned under the law as mandated reporters are: licensed physicians, residents or interns, law enforcement officers, judges presiding during a proceeding, nurses, schoolteachers, school officials, social workers, and Members of the clergy who have information not privileged as a matter of law.

- **Child Abuse**: Children, Youth, and Family Department's (CYFD) Statewide Central Intake child abuse hotline toll free at (855)333-SAFE [7233] or #SAFE from a cell phone, or to law enforcement or the appropriate tribal identity. Additional information regarding Child Protective Services can be found at: Children Youth and Family Department Central Abuse Line
- **Adult Abuse**: Adult Protective Services (APS) toll free Hotline at (866) 654-3219 or at (505)476-4912. Additional information regarding Adult Protective Services can be found on their website at: http://www.nmaging.state.nm.us/Contact_Us.aspx

2. Advance Directives

It is the policy of Molina Healthcare to ensure that all Members have access to information regarding the right to make informed decisions about their medical treatment, even when they can no longer speak for themselves. Advance Directive means written instructions (such as an Advance Health Directive, a Mental Health Advance Directive, a Psychiatric Advance Directive, a Living Will, a Durable Health Care Power of Attorney, or a Durable Mental Health Care Power of Attorney) recognized under State law relating to the provision of care when an individual is incapacitated.

Advance directives forms are state specific to meet state regulations. For copies of forms applicable to New Mexico, please go to the Caring Connections website at http://www.caringinfo.org/files/public/ad/NewMexico.pdf

A mental health or psychiatric advanced directive (PAD) is a legal document designed to preserve the autonomy of an individual with mental illness during times when the mental illness temporarily compromises the individual's ability to make or communicate mental health treatment decisions.

The Mental Health Care Treatment Decision Act gives all individuals >18 years of age the right to have a psychiatric advance directive and provides direction on the completion of a PAD and how organizations and providers must utilize a PAD. The law includes a standard PAD form, which is optional and not mandatory. For more information on PAD's in New Mexico and for a copy of the PAD form, link to: National Resource Center on Psychiatric Advance Directives

All practitioner/provider office personnel with Member contact must maintain a general knowledge of this policy and the contents of the "Advance Directives" article text.

3. Change of Address, Tax Identification Number, Open/Closed Panel, Affiliation, Name, etc.:

- Practitioners/Providers are required to notify Molina Healthcare within thirty (30) days of any change and/or addition. Notify your Provider Service Representative in writing:
- For Physical, Mailing, Name, TIN or Billing Address Change; include an updated IRS W-9 Form:
- When leaving or joining a new and/or additional practice, notification must be sent 30 days in advance.

4. Compliance with Cost-sharing Requirements

Molina Healthcare utilizes Member grievances to closely monitor practitioner/provider compliance regarding cost-sharing requirements. When a Member contacts Molina about a practitioner/provider balance billing beyond any applicable copayment amount, or is denied a service or benefit covered under Medicaid, Molina Healthcare will investigate the complaint and provide specific education to the practitioner/provider office/facility about their obligations under their contract and participation in the Medicaid program. When an emergent Member need arises, Molina Healthcare will investigate the complaint and take immediate action to remediate the issue.

5. Cultural Competency/Sensitivity and Diversity

Cultural Competence means a set of congruent behaviors, attitudes and policies that come together in a system or agency or among professionals that enables them to work effectively in cross-cultural situations. Cultural competency/sensitivity involves integrating and transforming knowledge, information and data about individuals and groups of people into specific clinical standards, service approaches, techniques and Marketing programs that match an individual's culture to increase the quality and appropriateness of health care and outcomes.

Molina Healthcare practitioners/providers and subcontractors must be aware of and sensitive to the cultural, ethnic and linguistic needs of our Members. As a contracted

practitioner/provider, you and your staff will receive orientation and information designed to facilitate communication with non-English speaking patients, patients who communicate using mechanisms other than a spoken language, and patients who do not hold mainstream health beliefs. Molina Healthcare provides a translation line to assist with Molina Healthcare Members that do not speak English.

Practitioners/providers are encouraged to contact Molina H ealthcare's Member Services Department to obtain assistance with our Members' cultural, ethnic, and linguistic needs:

- Language Line – available during Molina Healthcare's business hours to assist with language barriers; and
- Provider Directory – practitioner gender & languages spoken published.

Please call our Member Services Department in **Albuquerque at (505) 341-7493 or toll free (888) 825-9266** and a Member Services Representative will assist you.

For additional cultural competency resources and tools, practitioners/providers are encouraged to visit our website at www.molinahealthcare.com

To obtain additional information, or a copy of our "Learn about Diversity" pamphlet, please contact the Provider Services Department in **Albuquerque at (505) 342-4660 or toll free at (800) 377-9594**. Several websites also offer insight into diversity issues. These include the American Medical Association, American Medical Association and the Association of American Medical Colleges. To obtain a copy of Molina Healthcare's Cultural Competency Plan, please contact the Health Improvement Hotline in Albuquerque at **(505) 342-4660, ext. 182618 or toll free at (800) 377-5954, ext. 182618.**

6. Disease Reporting

As required by the State of New Mexico and the New Mexico Department of Health, all participating providers are required to report all applicable diseases as listed in the Notifiable Diseases or Conditions in New Mexico (7.4.3.13 New Mexico Administrative Code). The provider will notify the Epidemiology and Response Division **at (505) 827-0006** regarding confirmed or suspected communicable diseases, infectious diseases, and health conditions related to environmental exposures and certain injuries, occupational illness and injury, adverse vaccine reactions, healthcare-associated infections, sexually transmitted diseases, birth defects, and cancer.

All reports must include the following:

- The disease condition being reported;
- Patient's name, date of birth/age, gender, race/ethnicity, address, telephone number, and occupation;
- Physician or licensed healthcare professional name and telephone number; and
- Healthcare facility or laboratory name and telephone number, if applicable.

7. Documentation in the Medical Record

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. Standards for medical records have been developed to promote a consistent basis for documenting the provision of quality care and are in accordance with Regulatory and Accreditation requirements. An underlying principle in Medical Record Documentation Standards is to ensure continuity of care. Well-documented and accurate medical records demonstrate that coordination of care is occurring. Whether electronic or on paper this documentation facilitates communication, coordination, and continuity of care while promoting the efficiency and effectiveness of treatment.

Elements include but are not limited to: problem lists, preventive health summary sheets, referrals, diagnostic results and detailed prescription history including name, amount, route, instructions, refills and review of the effectiveness of the medication in treatment. These standards allow a provider who is seeing a new patient an opportunity to effectively review case history upon meeting the Member.

Practitioners/providers will maintain a medical record-keeping system that conforms with professional medical practice, permits effective internal and external quality review, permits encounter/claim review, and facilitates an adequate system for follow-up treatment. All medical records should be maintained against loss or destruction and retained for at least ten (10) years. Medical records are to be stored in a secure manner that permits easy retrieval. Only authorized personnel may have access to patient medical records.

In accordance with the HIPAA Privacy and Security Standards, providers will develop and implement appropriate safeguards to protect Member PHI. The provider will maintain the confidentiality of the medical record information, assuring that the contents of the medical record will be released to only as required or permitted under applicable federal and state law and regulations. The provider must ensure his/her staff receives periodic training regarding the confidentiality of member information.

The practitioner/provider will cooperate with Molina Healthcare and its representatives for the purposes of audits and the inspection and examination of medical records and other activities under Molina Healthcare's Utilization Management, Quality Improvement and Compliance Programs.

Routine medical record audits are performed annually on selected PCPs and OB/GYN practitioner files. Documentation from selected facilities or specialists may be requested to conduct focused reviews relating to areas of non-compliance found during the auditing period. Providers must maintain a compliance rating of eighty percent (80%) overall for medical record audits.

- Practitioners/providers not achieving a threshold score of eighty percent (80%) may be required to develop a corrective action plan and a re-audit may be required. Re-audits not producing a significant improvement may jeopardize the provider's contract.
- Audit results and educational materials addressing non-compliant areas will be sent to providers within thirty (30) business days following the audit. Educational classes

regarding medical record documentation are available upon request to the Quality Improvement Department of Molina Healthcare.

The following information is required in all Member records maintained by contracted providers subject to the Members age, gender and history:

- Is the record current, detailed and organized?
- Is the patient's name or identifier on each page?
- Are personal biographical data and consent forms as required by Human Services Department (HSD) in the file? This includes a signed Statement of Notification of Privacy Practices (HIPAA).Is each date of entry and date of encounter noted? Is the practitioner's signature or electronic identifier on each note?
- Are allergies or adverse reactions noted or no known drug allergy (NKDA) or no known allergy (NKA)?
- Is there a past medical history for patients seen two or more times? Is the status of preventive health services summarized on a single sheet and up to date within six (6) months of enrollment? (Adult only) Are current problems identified? Is the patient screened for smoking? (≥ twelve 12 yo) (Age parameter per State of New Mexico 's Quality Assurance Bureau) Is the patient screened for alcohol use? If positive for abuse, is screening tool used? (≥ twelve [12] yo) (Age parameter per State of New Mexico 's Quality Assurance Bureau)
- Is the patient screened for substance abuse? (≥ twelve [12] yo) (Age parameter per State of New Mexico 's Quality Assurance Bureau)
- Are advance directive or a discussion about advanced directives being offered for adults (≥ 18 yo) in the file or noted? (Age parameter per the State of New Mexico Quality Assurance Bureau.) Is the record legible? Is there a History & Physical for the current complaints, including psychological and social conditions affecting the patient's medical and psychiatric status?
- Is the plan of treatment noted?
- Does the file show the patients medication history, what has been effective, what has not and why?
- For drugs prescribed, does the practitioner note the name, strength, amount, directions for use and refills?
- Are follow-up plans for a return visit, and symptoms that should prompt a return visit documented? and
- Are new patients over age twenty-one (21) at first visit, screened for high-risk behavioral health conditions?

8. Employee Abuse Registry Act

All participating providers including all subcontractors and contracted providers must comply with the Employee Abuse Registry Act, NMSA 1978 § 27-7A-3, the New Mexico Caregivers Criminal History Screening Act, NMSA 1978, 29-17-2 et seq. and NMAC 7.1.9, the New Mexico Children's and Juvenile Facility Criminal Records Screening Act, NMSA 1978, §§ 32A-15-1 to 32A-15-4. The Patient Protection and Affordable Care Act requires that all subcontracted and contracted providers are screened against the New Mexico "List of Excluded Individuals/Entities" and the Medicare exclusion databases.

Participating practitioners/providers covered by the law include, but are not limited to:

- A care management entity that provides services to elderly people with developmental disabilities;
- Adult foster care homes;
- Group homes;
- Homes for the aged or disabled;
- Home health agencies; and
- Intermediate care facilities for the mentally retarded.

Participating practitioners/providers must document that they have checked the Registry for each applicant before the applicant was considered for employment or contract.

9. Emergency Care

Molina Healthcare defines a medical emergency as a condition that manifests itself by symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in: (a) jeopardy to the Member's health; or (b) serious impairment of bodily functions; or (c) serious dysfunction of any bodily organ or part; or (d) disfigurement of the person.

PCP Role in an Emergency Situation

To assist in reducing inappropriate use of emergency department (ED) facilities during normal business hours, PCPs MUST have a health professional available to triage patients under the following circumstances:

- Patients who walk into a PCP's office should be evaluated in a reasonable time frame to determine the emergent nature of the condition, and treatment should be scheduled that corresponds to the immediacy of the situation;
- Telephonic requests to the PCP's office by Members must be assessed to determine appropriate action;
- Telephonic requests to the PCP's office from other practitioners requesting approval to treat Members must be assessed for appropriateness; and
- The PCP must then advise the Member on a medically prudent course of action (i.e. whether to come to the office or to be referred for treatment to the emergency room at a participating hospital or urgent care center).

If the PCP is not available, practitioner back-up as part of the triage system should be provided by a practitioner having the same level or higher of training and specialty. PCPs are not required to submit referrals for patients they refer to an ER, but are encouraged to direct Members to appropriate care.

Out-of-Area Emergencies

Coverage for out-of-area emergencies is provided only for true emergency situations - those that could not have been anticipated. Routine medical services are not covered when provided outside the service area. Members are instructed to seek care at the nearest appropriate facility such as a clinic, urgent care center, or hospital Emergency Department.

When notified of an out-of-area emergency, which requires follow-up or has resulted

in an inpatient admission, the PCP is expected to monitor the Member's condition, arrange for appropriate care, and determine whether the Member can be safely transferred to a participating hospital.

10. Gross Receipts / Sales Tax

Molina Healthcare will reimburse Gross Receipt Tax (GRT) to applicable providers who meet the following criteria:

- The provider's practice is a for-profit entity; and
- They are required to pay GRT to the State of New Mexico.

Gross Receipts/Sales tax cannot be added to the charges of any patient who is a Member of a Health Plan or insurer of which a provider has made an agreement with to accept their reimbursement (Division of Insurance Regulation, 13 NMAC 10.13.27). Information such as tax tables and forms for Gross Receipts tax can be found on the New Mexico Taxation and Revenue Website: http://www.tax.newmexico.gov/All-Taxes/Pages/Gross-Receipts-Tax.aspx

11. Individualized Education Program (IEP) & PCP

The IEP is a written plan of care created for every child with a disability attending school. The IEP is a principle tenet of the Individuals with Disabilities Education Act (IDEA) that is developed, written and as appropriate, revised in accordance with the Act. It is the cornerstone for a special education student, ensuring his/her right to a free and appropriate education, including medically necessary services.

In addition to academic services, speech/language therapy, occupational therapy, physical therapy, social work, health services (i.e. medications, tube feedings), audiology and psychological services may be provided.

The primary care practitioner (PCP) for the child must receive a copy of the child's IEP if Medicaid reimbursable services are being requested. The PCP must then sign off on the plan of care to ensure he/she is aware of the medically necessary services that his/her patient is receiving at school.

It is important that the PCP sign off on the IEP and return it to the designated contact in the school setting. Per IDEA, schools are required to provide medically necessary services. However, without the PCP's signature, the schools cannot bill for services rendered. There is ***no medical liability or financial loss to the PCP*** in approving these services.

For more information on IEPs or the Medicaid School Services Based Program, please contact:
Medicaid School Based Services Program Manager
Medical Assistance Division Benefits Bureau
Local in Santa Fe (505) 827-6233 or
Medicaid School Based Services Program Director Medical Assistance Division Benefits Bureau **Local in Santa Fe (505) 827-3199**

12. Joining a Practice

Any practitioner changes (i.e. joining or leaving a practice) must be communicated to the appropriate Molina Healthcare Provider Services Representative and should be initiated at least thirty (30) days prior to the actual date of the change.

New Molina Healthcare Provider

- Complete a Provider Information Form (PIF) that is conveniently located on our Provider Website at www.molinahealthcare.com
- Complete the New Mexico Disclosure Form – this must be completed and submitted with the PIF located on our Provider Website at www.molinahealthcare.com
- Provide your CAQH (please make sure all information is up to date) information on the PIF, or complete a Credentialing Application;
- Send to your designated Provider Service Representative (fax or email); and
- Sign the appropriate contractual agreement, if necessary.

Existing Molina Healthcare Provider:

- Notify your designated Provider Service Representative of the change in practice within thirty (30) days of change. If notification is not received within thirty (30) days, credentialing must be completed (follow above steps as a new provider);
- Joining an existing contracted provider? Notification within thirty (30) days; or
- Opening a new practice? Notification within thirty (30) days; Complete New Mexico Disclosure Form; Complete a W-9; and if you are a PCP, OB/GYN or High Volume Behavioral Health schedule a site visit may be required.

13. Leaving a Practice/ Provider Termination

All Molina Healthcare contracted practitioners/providers and/or provider groups must notify Molina Healthcare and his/her Molina Healthcare patients of termination of an individual provider or of the entire group thirty (30) days prior to the effective date of termination. When terminating a Contracted Provider with Molina Healthcare:

- Notify your Provider Services Representative in writing;
- The Provider Services Representative will remove the terminating provider from various databases (including those that affect the production of an online or printed directory),claims processing system; and
- Molina Healthcare's Enrollment Department will notify Members of PCP changes. A Member assigned to a terminated PCP will be given adequate time to select a new PCP. If a new PCP is not selected, one will be assigned to him/her from a list of participating PCPs in his/her geographic area that is accepting new patients.

14. On-Call Arrangements

Molina Healthcare contracted providers must use practitioners that are contracted with Molina Healthcare for on-call arrangements. Practitioners must contact Molina Healthcare and obtain a prior authorization if a non-contracted practitioner is needed for on-call.

15. Open/Closed Panel

For PCPs, "Open Panel" indicates the practice is accepting new Members. "Closed Panel" indicates the practice is not accepting new Members. You must allow thirty (30) days notification of this change. Please notify your Provider Services Representative in

writing.

16. Promotional Activities

At the request of Molina Healthcare, Providers will display Health Plan promotional materials in its offices and facilities as practical, and cooperate with and participate in all reasonable marketing efforts so long as it does not violate Federal or State law or regulations. Providers will not use Molina Healthcare's name in any advertising or promotional materials without prior written permission.

17. Provider/Member Clinical Dialogue

Molina Healthcare does not place limitations on clinical dialogue. Molina Healthcare encourages open communication regarding treatment the provider feels is in the best interest of the patient, regardless of whether or not the particular treatment would be covered.

18. Providing and Measuring Access to Medical Care

Molina Healthcare is committed to providing its Members with accessible, timely, quality health care and services and is responsible for providing and maintaining appropriate access to primary medical care and services to all Members. Molina Healthcare is required to comply with access standards set forth by our regulators and the National Committee for Quality Assurance (NCQA). It is Molina Healthcare's policy to communicate established standards to all participating network providers. Molina Healthcare monitors performance annually for each of these standards as part of our Quality Improvement Program. This enables Molina Healthcare to identify opportunities for improvement.

The following information contained in this section defines the minimum requirements of timely access to care. Participating network practitioners/providers are required to comply with Molina Healthcare's access standards.

Appointment Availability Standards

Access Type	Request for Appointment or Wait Time
Routine, asymptomatic, Member-initiated, outpatient appointments for primary medical care	Request-to-appointment time will be no more than thirty (30) days (unless the Member requests a later time)
Routine asymptomatic, Member-initiated dental appointments	Request-to-appointment time will be consistent with community norms for dental appointments
Routine, symptomatic, Member-initiated, outpatient appointments for non-urgent primary medical and dental care	Request-to-appointment time will be no more than fourteen (14) days (unless the Member requests a later time)
Primary medical and dental care, outpatient appointments for urgent conditions	Will be available within twenty-four (24) hours

Specialty outpatient referral and/or consultation appointments	Request-to-appointment time will be consistent with the clinical urgency but no longer than twenty-one (21) days (unless the Member requests a later time)
Routine outpatient diagnostic laboratory, diagnostic imaging, and other testing appointments	Request-to-appointment time will be consistent with the clinical urgency but no more than fourteen (14) days (unless the Member requests a later time)
Routine, asymptomatic, Member-initiated Behavioral Health Appointments	Request-to-appointment time will be within fourteen (14) days
Behavioral Health Urgent Care Appointment	Request-to-appointment time will be within twenty-four (24) hours
Behavioral Health Crisis Services Appointment	Request-to-appointment time will be within two (2) hours
Behavioral Health Life-threatening Emergency	Immediate Access
Post-Discharge Behavioral Health Appointment	Follow up appointment within seven (7) days
After Hours Care	Twenty four (24) hour coverage
Outpatient diagnostic laboratory, diagnostic imaging and other testing appointments, if a "walk in" rather than an appointment system is used	Wait time will be consistent with severity of the clinical need

Urgent outpatient diagnostic laboratory, diagnostic imaging, and other testing appointments	Request-to-appointment time will be consistent with the clinical urgency, but no more than forty-eight (48) hours
Pharmacy Services	In-person prescription fill time (ready for pickup) will be no longer than forty (40) minutes; a prescription phoned in by a practitioner will be filled within ninety (90) minutes

Durable Medical Equipment (DME)
▪ Urgent
▪ Non-urgent
  ▪ New customized or made to measure DME, or customized modifications to existing DME owned or rented by the Member
  ▪ DME repairs or non-customized modifications
	▪ Will be delivered within twenty-four (24) hours of the request
	▪ Will be delivered within a timeframe consistent with clinical need
	▪ Will be delivered within one hundred fifty (150) days of request
	▪ Will be delivered within sixty (60) days of request date

Transportation Services (contact ITM for scheduling and prior authorization)	Require forty-eight (48) hour notice Transportation for sudden, urgent situations may be arranged with less notice

Member Service Telephone Services ▪ Average Speed to Answer ▪ Average Abandonment Rate ▪ Answer ninety-five percent (85%) of Member calls	 ▪ ≤ Thirty (30) seconds ▪ ≤ Five percent (5%) ▪ ≤ Thirty (30) seconds

The use of telehealth technology is supported to improve access to care in rural and frontier areas of the state. Molina Healthcare offers technical assistance, training and other support for providers willing to provide or receive services via telehealth technology.

Molina Healthcare monitors Member access to care through a number of mechanisms including:

- Annual After-Hours Telephone Survey: Provider offices are called after business hours to determine whether the call was answered by a live-person or a recording; whether or not emergency instructions were provided; and had sufficient means to speak with a practitioner;
- Annual Appointment Availability Survey: Telephone surveys are conducted annually to measure performance against Access Standards for Primary Medical Care Services;
- Annual Member Satisfaction Survey; conducted annually through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey;
- Ongoing Member Complaints Data: The rate of Member complaints relating to access and availability of care;
- Ongoing Report of Member Telephone Statistics: Molina Healthcare assesses the accessibility of Member services through ongoing measurements of average speed to answer; average abandonment rates; and percentage of calls answered within thirty (30) seconds or less; and
- Annual Healthcare Effectiveness Data and Information Set (HEDIS®) Access and Availability of Care Measures: These measures look at how Members access services from his/her health care delivery system, such as: adult's access to preventive/ambulatory services; children's access to PCPs; timeliness of prenatal and postpartum care; and annual dental visits.

On an annual basis, Molina Healthcare compiles results from the various monitoring activities to conduct a comprehensive analysis to identify barriers and areas for improving Member access to care.

Molina Healthcare requires that all contracted practitioners/providers offer the same office hours to Molina Healthcare Members that are offered to all other patients under Commercial Plans and/or Medicaid Fee for Service.

19. Missed Appointments

When practitioners/providers experience problems with Members who fail to show for appointments, this information should be relayed to Member Services. Molina Healthcare will assist in educating the Member about the need to cancel or reschedule appointments prior to the time of his/her appointment. The practitioner/provider will document missed appointments and recall efforts in his/her appointment system or the Member's medical record.

20. Request for Patient Medical or Treatment Records

It is sometimes necessary for Molina Healthcare to request medical records from a practitioner/provider. Molina Healthcare staff will initiate requests for records from various departments including, but not limited to, the following: Claims, Utilization and Medical

Management, Quality Improvement, Fraud, Waste and Abuse Program, Member Advocacy, Credentialing, Finance, and Administration as the HIPAA minimum necessary rule dictates.

Molina Healthcare will reimburse the practitioner/provider or his/her contracted vendor for copies of records requested, but not actually copied by Molina Healthcare and/or a Molina Healthcare vendor, and for collection of hybrid HEDIS® set data. **Payment will be made only according to strict criteria established by Molina Healthcare.**

Reimbursement will not be made for copies of records requested by Molina Healthcare staff for: utilization and medical management, care validation, anti-fraud program reviews, or suspected quality of care concerns.

21. Vaccines for Children Program

Molina Healthcare practitioners located in New Mexico are required to enroll in the Vaccines for Children (VFC) Program. VFC provides vaccines at no charge to immunize Molina Healthcare Members under the age of eighteen (18). For more information on:

- Enrolling with VFC, contact VFC at (866) 681-5872. **For more information, please see the New Mexico Immunization Program's website at:** http://nmhealth.org/about/phd/idb/imp and/or
- The New Mexico Statewide Immunization Information System to record immunizations administered in your clinic or healthcare facility, contact the NMSIIS website at: https://nmsiis.health.state.nm.us/PR/portalInfoManager.do

22. Transition of Care after Termination

All Molina Healthcare contracted practitioners/providers terminating their contracted status with Molina Healthcare, including groups, are required to follow appropriate Transition of Care guidelines for Molina Healthcare patients under a current course of treatment or care of the terminating provider or group. This includes seeing Molina patients for no more than ninety (90) calendar days after termination until the Molina Healthcare patient's current episode of care is resolved or until the Molina Healthcare patient has been appropriately transitioned to another contracted Molina Healthcare practitioner/provider.

The practitioner/provider will also:

- Not bill any Molina patients in this ninety (90) transition period for Covered Services with the exception of any applicable Copayments, Deductibles and/or Coinsurance;
- Accept the contracted rate reflected in the Agreement as payment in full during the ninety (90) Day transition period or until such time as the Molina patient's episode of care is resolved or is transitioned to another contracted Molina Healthcare practitioner/provider;
- Continue to follow Molina Healthcare's Utilization Managed policies and procedures; and
- Share any information requested, included medical records, regarding the treatment plan with Molina Healthcare.

Section 13 – Fraud, Waste and Abuse

A. Introduction

Molina Healthcare of New Mexico 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 New Mexico 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 New Mexico will uphold and follow state and federal statutes and regulations pertaining to fraud, waste, and abuse. Molina's Special Investigation Unit supports Compliance in its efforts to deter and prevent fraud, waste, and abuse by conducting investigations to identify and report findings to the appropriate regulatory and/or law enforcement agencies. The program also addresses fraud prevention and the education of appropriate employees, vendors, providers and associates doing business with Molina Healthcare of New Mexico.

B. Mission Statement

Molina Healthcare of New Mexico 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 New Mexico 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.

C. Regulatory Requirements

Federal False Claims Act

The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. Government for payment. The term "knowing" is defined to mean that a person with respect to information:

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

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

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

Health care entities like Molina Healthcare of New Mexico 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 New Mexico, 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 New Mexico contracted providers to ensure compliance with the law.

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

Waste:
Health care spending that can be eliminated without reducing the quality of care. Quality Waste includes, overuse, underuse, and ineffective use. Inefficiency Waste includes redundancy,

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

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

Examples of Fraud, Waste and Abuse by a Provider

- Billing for services, procedures and/or supplies that have not actually been rendered.
- Providing services to patients that are not medically necessary.
- Balance Billing a Medicaid member for Medicaid covered services. For example, asking the patient to pay the difference between the discounted fees, negotiated fees, and the provider's usual and customary fees.
- Intentional misrepresentation or manipulating the benefits payable for services, procedures and or supplies, dates on which services and/or treatments were rendered, medical record of service, condition treated or diagnosed, charges or reimbursement, identity of provider/practitioner or the recipient of services, "unbundling" of procedures, non-covered treatments to receive payment, "up-coding", and billing for services not provided.
- Concealing patients misuse of Molina Healthcare of New Mexico 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)

D. Review of Provider

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

- Federal and State Medicaid sanction reports.
- Federal and state lists of excluded individuals and entities.
- 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.

E. Provider Profiling

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

Molina Healthcare of New Mexico will inform the provider of the billing irregularities and request an explanation of the billing practices. The Compliance department, with the aid of the Special Investigation Unit, may conduct further investigation and take action as needed.

Provider/Practitioner Education

When Molina Healthcare of New Mexico 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 New Mexico may determine that a provider/practitioner education visit is appropriate.

The 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.

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 New Mexico 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.

Cooperating with Special Investigation Unit Activities

Molina Healthcare's Special Investigation Unit may conduct prepayment, concurrent, or post-payment review. Providers will cooperate with Special Investigation Unit activities, and will provide requested documentation to the unit following the timelines indicated in such requests.

Failure to cooperate may result in further action, up to and including termination of the Provider contract.

F. 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 1-866-606-3889 or you may use the service's website to make a report at any time at **https://molinahealthcare.alertline.com**

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

Molina Healthcare of New Mexico
Attn: Compliance
400 Tijeras Ave NW, Suite 200
Albuquerque, NM 87102
Remember to include the following information when reporting:

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

Suspected fraud and abuse may also be reported directly to the state at:

Medical Assistance Division
Quality Assurance Bureau
P.O. Box 2348
Santa Fe, NM 87504-2348
NMMedicaidFraud@state.nm.us
Santa Fe: (505) 827-3100
Toll free: (888) 997-2583

New Mexico Human Services Department
Office of Inspector General
Local in Albuquerque: (505) 827-8141
Toll free: (800) 338-4082
HSDOIGFraud@state.nm.us Local in

Medicaid Fraud Control Unit 111 Lomas NW, Suite 300
Albuquerque, NM 87102
Local in Albuquerque: (505) 222-9000 or Toll free: (800) 678-1508

Section 14 – Preventive Health Guidelines and Clinical Practice Guidelines

A. Preventive Health Guidelines

The objective of Molina Healthcare of New Mexico, Inc. (Molina Healthcare) is the delivery of a core package of clinical preventive health services that will be beneficial to the practitioner and his/her patients. These guidelines are derived predominately from the latest recommendations of the *United States Preventive Services Task Force*; *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* published by the National Center for Education in Maternal and Child Health, American Academy of Pediatrics; Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices, and other professional organizations. Although there is a wide array of preventive services, we have chosen to identify age specific preventive interventions and have prioritized them based on the effectiveness of interventions that improve outcomes. These guidelines are meant to be a standard level of care and do not preclude the delivery of additional preventive services depending on the individual needs of the patient.

Providers may contact Molina Healthcare Health Improvement Program for a complete set of our Preventive Health Guidelines for Children, Adolescents, Adults and Pregnancy or see the Molina Healthcare web link to obtain them.
http://www.molinahealthcare.com/medicaid/providers/nm/resource/pages/guide_prevent.aspx

B. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

The EPSDT Program is a federally mandated program ensuring comprehensive health care to Medicaid recipients from birth to twenty-one (21) years of age. EPSDT visits include:

- Comprehensive health and development history;
- Comprehensive unclothed physical exam including height, weight and BMI percentile;
- Appropriate immunizations according to the most current Advisory Committee on Immunization Practices (ACIP) Schedule*
- Laboratory tests including Hematocrit/Hemoglobin at nine (9) months and thirteen (13) years;
- Blood Lead Screening at twelve (12) and twenty-four (24) months;
- Nutrition screening;
- Development/Behavioral Assessment;
- Health education and Anticipatory Guidance;
- Dental Screening; and
- Vision and Hearing Screening.

If any component of the above EPSDT screen is not completed, this must be noted in the medical record including whether the EPSDT or Well Child Check was offered and declined, or the patient/guardian chose not to complete the screen.

Practitioners who have implemented a formal system for delivering preventive services increase his/her delivery in the clinical setting. There is also scientific evidence to support

the effectiveness of using certain tools in a system to deliver preventive services - such as preventive care flow sheet, reminder notes on patient charts, and patient reminders. Molina Healthcare currently mails out educational reminders through its monthly Patient Appointment Reminder Card for children and adults.

C. Tot-to-Teen Health Checks

The initial screening component of the EPSDT Program is called the Tot-to-Teen Health Check. The Primary Care Practitioner (PCP) initiates all follow-up and referral services at the Tot-to-Teen Health Check.

D. Claims Processing

Submit the Centers for Medicare & Medicaid Services (CMS)-1500 (08/05) form with the encounter code from the following codes. For reference, the following resources are available to assist with coding for EPSDT visits including ICD-10 codes:

Bright Futures Preventive Medicine Coding Fact Sheet
https://www.aap.org/en-us/Documents/coding_factsheet_brightfuturespreventivemedicine.pdf

Medicaid.gov Keeping America Healthy: EPSDT
http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html

Envision New Mexico EPSDT Resource Handbook
http://envisionnm.org/xpdf/EPSDT_Resource_Handbook.pdf

Immunizations Codes
Vaccine Specific Current Procedural Terminology (CPT) Code with corresponding Administration Code.

Practitioners must document all immunizations administered in the New Mexico Statewide Immunization Information System (NMSIIS). For assistance, please contact Provider Services. All practitioners that enter immunizations into NMSIIS will receive an incentive of five dollars when billing CPT-4 code 99080 in conjunction with the immunization codes.

Blood Lead Screen Code
CPT-4 code: 83655
Practitioners are encouraged to follow the New Mexico Department of Health protocols for Childhood Blood Lead Screening. Molina Healthcare provides these protocols to practitioners in the EPSDT Provider Toolkit.

Vision Screening at Twelve (12) and Twenty-four (24) Months
CPT-4 code: 99173
Hearing Screening
CPT-4 code: 92551 – 92553, 92555 – 92556, 92587 (in conjunction with well child exam)

Developmental screening: Thirty (30) months
CPT-4 code: 96110

EPSDT Periodicity Schedule
The basic schedule for Tot-to-Teen Health Checks is as follows (see this Section for full description of each of the following office visits):

Infancy	**Early Childhood**
By one month	12 months
At two months	15 months
4 months	18 months
6 months	24 months
30 months (developmental screen)	3 years
9 months	

Middle Childhood	**Adolescence**
4 to 11 years	12 to 20 years

Appointment Scheduling Assistance
EPSDT patients may receive assistance with appointment scheduling by contacting Molina Healthcare's Member Services Department directly in **Albuquerque at (505) 341-7493 or toll free (888) 825-9266.**

Transportation
EPSDT also provides assistance with transportation to and from appointments under certain circumstances. Patients may contact Integrated Transport Management, Inc. (ITM) **toll free at (888) 593-2052.**

EPSDT Provider Tools
Molina Healthcare has Provider Engagement Team (PET) tools and resources available that contains information to assist your practice in understanding the importance of EPSDT and to encourage proper documentation of preventive services provided to your patients. For your copy of EPSDT Provider tools, call the Health Improvement Hotline in **Albuquerque at (505) 342-4660 extension 182618 or toll free at (800) 377-9594 extension 182618.**

For more information about documentation of preventive health services provided to children and adolescents, contact the Health Improvement Hotline in **Albuquerque at (505) 342-4660 extension 182618 or toll free at (800) 377-9594 extension 182618.**

E. Preventive Health Standards

As a part of continuous quality improvement, Molina Healthcare encourages practitioners to routinely document preventive health screenings including laboratory tests and immunizations. Practitioners are expected to document all immunizations given to Members in the New Mexico Statewide Immunization Information System (NMSIIS). Molina Healthcare will consider the following when evaluating services provided:

- Were immunizations for adults offered as appropriate? (Flu, Pneumococcal, Tetanus & Varicella) Or is there a note that immunizations were offered and patient refused to consent and/or refused access to care?
- Has the patient had a Mammography in the last one to two years? (Females aged 40-69 years) Or is there a note that mammography was offered and patient refused to consent and/or refused access to care?
- Has the patient (females twenty-one [21]-sixty-five [65] years) had a Papanicolaou (PAP) in the last three (3) years? If the patient is at high risk, is there an annual PAP? If a PAP is not done, is there a note that the screen was offered and the patient refused to consent and/or refused access to care?
- Has the patient had a colorectal cancer screen by fecal occult blood in the last year, or colonoscopy or sigmoidoscopy or double contrast barium periodicity to be determined by the practitioner (Adults $\geq$ fifty [50] years old)? If screen not done, is there a note that the screen was offered and the patient refused to consent and/or refused access to care?
- Has the patient (over age eighteen [18]) received a blood pressure measurement at least every two (2) years? If screen not done, is there a note that the screen was offered and the patient refused to consent and/or refused to access care?
- Are all sexually active women age twenty-five (25) or younger screened for Chlamydia?
- Are all female Members over age twenty-five (25) who are considered at high risk (inconsistently use barrier contraception, have more than one (1) sex partner, or have had a sexually transmitted disease in the past) screened for Chlamydia? If the test not done is there a note that the screen was offered and the patient refused to consent and/or refused to access care?

F. Preventive Health Specific to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Visits Up to the Age of Twenty- One (21)

- Is there a comprehensive health and developmental history, including assessment of physical and mental health development?
- Is there a comprehensive unclothed physical exam?
- Are there appropriate immunizations to age and history unless contraindicated? If immunizations are not done, is there a note that they were offered and refused (included refusal to access care), or is there documentation that copies of immunizations were requested and not brought in?
- Laboratory tests, including an appropriate lead blood level assessment at age one (1) and prior to two (2) years old.
- Is health education including anticipatory guidance documented?
- Are vision and hearing test orders and results documented?
- If not done, is there a note that the EPSDT or Well Child Check was offered and declined, or the patient/guardian chose not to access?

G. Preventive Health Standards for Pregnancy

- Is the patient screened for preeclampsia in accordance with the most current American College of Obstetricians and Gynecologists (ACOG) recommendations? If not done, is there a note that the screen was offered and the patient refused to consent and/or refused

to access care?

- Is the patient screened for Rh incompatibility in accordance with the most current ACOG recommendations? If Rh test was not done, is there a note that the screen was offered and the patient refused to consent and/or refused to access care?
- Is the patient's fetus screened for Down's syndrome and neural tube defects in accordance with the most current ACOG recommendations-Maternal Serum Alpha-Fetoprotein (MSAFP)? If test not done, is there a note that the screen was offered and refused (including refused to access care) or a note of "too late" as pregnancy is beyond twenty (20) weeks?
- Is the patient screened for hemoglobinopathies in accordance with the most current ACOG recommendations Hematocrit (H & H)? If H & H not done is there a note that the screen was offered and the patient refused and/or refused to access care?
- Is the patient screened for vaginal and rectal group B streptococcal infection in accordance with the most current ACOG recommendations? If screen not done, is there a note that the screen was offered and the patient refused and/or refused to access care?
- Is the patient screened and counseled for Human Immunodeficiency Virus (HIV) in accordance with the most current ACOG recommendations? If screening and counseling not done, is there a note that the screen was offered and the patient refused to consent and/or refused to access care?

For more information about documentation of preventive health services provided to children, adolescents, and adults contact the Health Improvement Hotline in **Albuquerque at (505) 342- 4660 extension 182618 or toll free at (800) 377-9594 extension 182618**.

H. Clinical Practice Guidelines

Clinical Practice Guidelines are available for review and printing on the Molina Healthcare website at www.molinahealthcare.com in the Clinical Practice Guideline section. If you do not have internet capability, a hard copy of any Clinical Practice Guideline can be mailed to you. Contact Provider Services in Albuquerque (505) 342-4660 or toll free (800) 377-9594.

Clinical Practice Guidelines are available for the following conditions:

- Acute Otitis Media
- Asthma
- Asthma Action Plan for NM Schools
- Bronchitis
- COPD
- Diabetes
- Heart Failure
- Hypertension
- Low Back Pain
- Obesity
- Upper Respiratory Infection

Section 15 – Privacy Practices and Health Insurance Portability and Accountability Act (HIPAA)

A. Molina Healthcare's Commitment to Patient Privacy

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

B. Provider Responsibilities

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

Telehealth/Telemedicine Providers. Telehealth transmissions are subject to HIPAA-related requirements outlined under Centennial Care, including:

- 42 C.F.R. Part 2 regulations
- Health Information Technology for Economic and Clinical Health Act, ("HITECH Act")

Under HIPAA, a Business Associate Agreement between the healthcare provider and telehealth technology provider must be in place. This precludes the use of free versions of Skype, VSee or other video transmission services, which provide no assurances regarding the protection of log files or other data captured during a telemedicine encounter.

C. Applicable Laws

Practitioners/providers 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 must comply with. In general, most healthcare providers 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;
   - Federal Alcohol and Drug Abuse Confidentiality Regulations [42 CFR Part 2]; and
2. Applicable New Mexico Laws and Regulations.

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

D. 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 practitioner/provider 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 practitioner's own TPO activities, but also for the TPO of another covered entity. (See Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule). Disclosure of PHI by one covered entity to another covered entity, or health care provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a healthcare provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services." (See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule.)

2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:
   - Quality improvement;
   - Health management;
   - Care management and care coordination;
   - Training Programs; or
   - Accreditation, licensing, and credentialing.

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

E. Confidentiality of Alcohol and Substance Abuse Patient Records

Federal Alcohol or Substance Abuse Confidentiality Regulations apply to any entity or individual providing federally assisted alcohol or drug abuse prevention functions. Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with alcohol or drug abuse treatment or programs are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects substance abuse information, the federal alcohol and substance abuse regulations are more restrictive than HIPAA and they do not allow disclosure without the Member's written consent except in very limited circumstances.

F. Written Authorizations

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

G. Patient Rights

Patients are afforded various rights under HIPAA. Molina Healthcare providers must allow

patients to exercise any of the below-listed rights that apply to the practitioner/provider's practice:

1. **Notice of Privacy Practices**
   Practitioners/providers 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 should obtain a written acknowledgment that the patient received.

2. **Requests for Restrictions on Uses and Disclosures of PHI**
   Patients may request that a healthcare provider restrict its uses and disclosures of PHI. The practitioner/provider is not required to agree to any such request for restrictions.

3. **Requests for Confidential Communications**
   Patients may request that a healthcare provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests by the patient.

4. **Requests for Patient Access to PHI**
   Patients have a right to access their own PHI within a provider'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 practitioner/provider includes the patient's medical record, as well as billing and other records used to make decisions about the Member's care or payment for care.

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

6. **Request Accounting of PHI Disclosures**
   Patients may request an accounting of disclosures of PHI made by the practitioner/provider 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.

H. HIPAA Security

Practitioners/providers should implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability and integrity of Member PHI. Practitioners/providers 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 health care 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. Practitioners/providers should be aware of this growing problem and report any suspected fraud to Molina Healthcare.

I. HIPAA Transactions and Code Sets

Molina Healthcare strongly supports the use of electronic transactions to streamline health care administrative activities. Molina Healthcare providers 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; and
- Remittance advices.

Molina Healthcare is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers who wish to conduct HIPAA standard transactions with Molina Healthcare should refer to Molina Healthcare's website at www.molinahealthcare.com or Molina Healthcare's Provider Portal at HIPAA Resource Center for additional information.

J. National Provider Identifier (NPI)

All practitioners/providers requesting reimbursement for services must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The provider 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. Practitioners/providers must use its NPI to identify itself on all electronic transactions required under HIPAA and on all claims and encounters (both electronic and paper formats) submitted to Molina Healthcare.

K. Additional Requirements for Delegated Providers

Practitioners/providers 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 must agree to various contractual provisions required under HIPAA's Privacy and Security Rules.

L. Reimbursement for Copies of PHI

Molina Healthcare does not reimburse providers for copies of PHI related to our program Members. These requests may include, although are not limited to, the following purposes:

- Utilization Management;
- Care Coordination and/or Complex Medical Care Management Services;
- Claims Review;
- Resolution of an Appeal;
- Anti-Fraud Program Review;
- Quality of Care Issues;
- Regulatory Audits;
- Treatment, Payment and/or Operation Purposes; and
- Collection of HEDIS® medical records.

Section 16 – Claims and Reimbursement

Prior to contracting with Molina Healthcare, providers must be enrolled with New Mexico Medicaid. All providers with a National Provider Identifier (NPI) that is not associated with an active New Mexico Medicaid Fee-For-Service or Managed Care Provider record (status 60 or 70) in the Omnicaid system and has or will provide health care services are required to enroll with the New Mexico Medical Assistance Division (MAD) Medicaid Program or their claims will be denied.

A. Initial Claims Submissions

Participating practitioners/providers are required to submit claims within ninety (90) days from the date of service when Molina Healthcare is the Member's primary insurance. All claims must be submitted within one (1) year from the date of service when Molina Healthcare is the secondary carrier when the primary carrier's filing limit is one (1) year, and within ninety (90) days of the other carrier's Explanation of Benefit (EOB).

Practitioners/providers are required under ACA to submit claims electronically using the standard CMS -1500 or UB-04 claim form. Providers must use a 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: The completed UB 04 data set or its successor format adopted by the National Uniform Billing Committee (NUBC), submitted on the designated paper or electronic format as adopted by the NUBC. Entries stated as mandatory by NUBC and required by federal statue and regulations and any state designated data requirements included in statues or regulation.
- Physicians and Other Professional Providers: The Centers for Medicare and Medicaid Services (CMS) Form 1500 or its successor adopted by the National Uniform Claim Committee (NUCC) submitted on the designated paper or electronic format utilizing Current Procedural Terminology (CPT) codes and modifiers and International Classification of Diseases (ICD) codes. Entries states as mandatory by NUCC and required by federal statute and regulation and any state designated data requirements included in statutes or regulations.

B. Corrected Claims Submissions

Corrected claims must be submitted with the appropriate indicator based upon the form type to ensure that they are not mass adjudicated as duplicate claims. Corrected claims must be submitted within six (6) months of the remittance advice from the original claim.

CMS-1500 forms: All corrected claims must include indicator "7" in Box 22-Medicaid Resubmission Code, and the original Molina Healthcare claim number in Box 22-Original Ref. No.

UB-04 forms: Bill type frequency (4^{th} Digit) must be one of the following:
0XX5 – Late Charges Only Claim
0XX7 – Replacement of a prior claim
0XX8 – Void/Cancel of a prior claim

C. Encounter Data

Molina Healthcare is required by the New Mexico Human Services Department to report all services rendered to MHNM Members. The reporting of these services, also known as encounter data reporting is a critical contractual requirement. Molina Healthcare works closely with its providers and subcontractors to ensure they are in compliance with Encounter Data submission requirements. This includes training, technical assistance and other activities to support providers and subcontractors to ensure compliance with the HIPAA 837 format. Molina Healthcare also partners with the clearinghouse Emdeon to identify opportunities to assist practitioners/providers to use electronic claims submission and improve the quality of claims and encounter data submitted.

D. Electronic Claims Submission / EDI

The State of New Mexico Human Services Department (HSD) requires that all of Molina Healthcare practitioners/providers file all claims electronically. All contracted practitioners/providers that are unable to file claims electronically must notify Provider Services with the reason(s). The benefits of Electronic Data Interchange (EDI) are:

- Efficient information delivery;
- Reduced operational costs associated with paper claims (printing, correlating, and postage);
- Increased accuracy of data; and
- Ensure HIPAA compliance.

Forms and additional information can be obtained via our website: Benefits of Using EDI

E. "Clean" Claim Criteria

The following items **must** be included to be considered a "clean" claim:

- Member's name;
- Member's correct date of birth;
- Provider's National Provider Identifier (NPI);
- Complete diagnosis code carried out to the highest degree (4th or 5th digit);
- Valid date of service;
- Valid Current Procedural Terminology (CPT-4) code or Health Care Procedure Coding System (HCPCS) code;*
- Valid Revenue (REV) codes; and
- Valid modifiers (if appropriate);

Molina Healthcare will pay interest each month on the amount of a clean claim (based upon the current Medicaid fee schedule) and not paid within 30 calendar days of the date of receipt of an electronic claim and 45 calendar days of receipt of a paper claim. Interest will accrue from the 31st calendar day for electronic claims and from the 46th calendar day for manual claims.

***Telehealth providers:** For professional service, use the usual service code and add a GT modifier as appropriate (example: 90801 GT) to indicate service was provided via telehealth. Only one service code is specific to telehealth. Q3014 facility fee compensates providers who support telehealth patient sites.

F. Coordination of Benefits (COB)

Providers should maintain current coverage information on all Members.

1. **Order of Benefit Determination**

COB is a method of determining who has primary responsibility when there is more than one insurance coverage available to pay benefits. The combined payments provided by the primary and secondary plans cannot be more than the total of charges. When benefits are coordinated by Medicaid (payer of last resort), the total payment will not exceed the Medicaid eligible payment.

Molina Healthcare follows the "Order of Benefit Determination Rules" to identify the primary insurance carrier. These rules are explained below:

- The program that covers the patient as an employee is primary;
- If an individual is a covered Member by more than one (1) group program as an active employee and as a retired employee, the program covering the individual as an active employee is primary. this rule also applies to dependents of the Member;
- If an individual is enrolled in a group retiree program and also as a dependent on an active working spouse's coverage, the dependent's active coverage is primary;
- **Molina Healthcare will be the payer of last resort.** Centennial Care claims will represent the balance of the eligible amount minus the payment from the primary insurance company. The combined payments will not exceed what would normally have been paid by Molina Healthcare in the absence of other coverage. If the payment from the primary insurance company is equal to or greater than the Medicaid Fee Schedule or contractual amount, no payment will be made by Molina Healthcare. The provider is **not** permitted to bill the Centennial Care Member for the balance.
- When two (2) plans cover the same child as a dependent (parents NOT separated or divorced), and neither plan is a Medicaid program:
  - The plan of the parent whose birthday falls earlier in the year is primary over the plan of the parent whose birthday falls later in the calendar year; but
  - If both parents have the same birthday, the plan that covered one (1) parent longer is primary over the plan that covered the other parent for a shorter time; or
  - If the other coverage plan does not use the birthday rule described above, but instead uses a rule based on the gender of the parent, the rule of the other plan will determine the order of benefits.
- When two plans cover the same child as a dependent (parents are separated or divorced), the primary payer is determined in this order:
  - First , the plan of the parent who has custody of the child;
  - Second, the plan of the spouse of the parent who has custody of the child;
  - Third, the plan of the natural parent not having custody of the child; or
  - If the specific terms of a court decree require one parent to be responsible for the dependent's health care expenses, that parent's plan will be primary over any other plan covering the child as a dependent. This applies as long as the plan designated as primary has actual knowledge of those terms.
- If none of the above rules establishes an order of benefits, the plan that covered the person longer is primary over the plan that covered the person for a shorter time; and
- If it is determined that a Centennial Care Member has Medicare, their coverage will coordinate with the appropriate Centennial Care Plan. All claims should be submitted to

Medicare or Medicare Managed Care Plan as the primary carrier, then to the appropriate Centennial Plan for secondary payment.

2. **Submitting COB Claims**
   When submitting claims for Members for which Molina Healthcare is not the primary insurance, you must attach a copy of the primary payer's EOB with the exception of home services billed by Early, Periodic Screening and Diagnostic Treatment (EPSDT) Providers for waiver children, prenatal and pregnancy care. Molina Healthcare will bill the primary insurance directly for these services unless the rendering practitioner/provider has already done so, and has provided the primary payer's EOB. The primary payer's EOB must match the submitted claim, and include descriptions of all associated remit messages so that Molina Healthcare may appropriately consider the charges.

3. **Revenue Codes**
   Practitioners/providers are required to use industry standard billing forms and coding. Claims submitted on a UB-04 form should include the appropriate type of bill, specific revenue codes and HCPCS or other codes as appropriate for services.

   Skilled nursing facility (SNF), sub-acute care, or psychiatric services should be billed with the appropriate specific revenue codes and should not be billed using general medical surgical revenue codes.

G. Timely Filing Suggestions

Please follow these *suggestions* in order to facilitate timely reimbursement of claims and to avoid timely filing issues:

- Submit your electronic claims within forty five (45) days of providing the service, and your paper claims within thirty (30) days of providing the service;
- Check the status of your claims no sooner than thirty (30) days from the date of your original submission;
- If, after forty-five (45) days from submission of your claim(s), you have not received payment/denial, please call Member Services to confirm receipt of your claim(s) and be certain to document the name of the person you spoke with and the date of the call; and
- If Molina Healthcare does not have record of receipt of your claim(s), please immediately resubmit. Resubmission should only occur if Molina Healthcare does not have record of your original claim submission.
- Submit any/all corrections within six (6) months of the remittance advice from the original submission of the claim.

H. Key to EOB Messages

Explanation of benefits (EOB) is defined on the EOB document sent with claims (i.e. payments, adjustments, denials, etc.). P lease call Member Services if additional information is needed. The EOB is a single document with pages clearly and consecutively numbered. The EOB includes:

- The check, if applicable, is printed on the lower third of the first page;
- All settled claims within the Remittance Advice (RA) run cycle appear in alphabetical order first by rendering provider, then by patient last name, first name, and middle initial. If there

are multiple claims for the same patient, they are presented in the order they were processed;
- Reason codes are conveniently displayed at the charge line or summarized at the end of the remittance advice or directly below the explanation of payment for the specified claim; and
- Each claim has a heading, which includes the provider internal patient account number (control number).

I. Claim Resubmission/Adjustments

ALL requests must include sufficient documentation to support the request. The Provider Reconsideration Review Request Form (PRR) can be accessed on the Molina Healthcare website at this link: **PRR Form**

All claims resubmission or adjustment requests must be submitted and received by Molina Healthcare within:

- One Hundred Eighty (180) days of dated correspondence from Molina Healthcare referencing the claim (correspondence must be specific to the referenced claim);
- One (1) year from the date of service when Molina Healthcare is the secondary payer when the primary carrier's filing limit is one (1) year, and ninety (90) days of the other carrier's EOB; and
- Ninety (90) days of the other carrier's EOB when submitted to the wrong payer.

Acceptable Proof of Timely Filing - Acceptable proof of timely filing includes, but is not limited to any one item or combination of:

- EOB issued by Molina Healthcare;
- Provider statements/ledgers indicating the original submission date as well as all follow-up attempts;
- Dated copy of Molina Healthcare correspondence referencing the claim (correspondence must be specific to the referenced claim);
- Other carrier's EOB when Molina Healthcare is the secondary payer (one [1] year from the date of service);
- Other carrier's EOB when submitted to the wrong carrier (ninety [90] days); and
- Documentation of inquiries (calls or correspondence) made to Molina Healthcare for follow- up that can be verified by Molina Healthcare.

J. Claim Edits

Molina Healthcare with external vendors performs prepayment claim audits. These vendors use Medicare (i.e., CMS) claim edits and other industry standard coding guideline such as Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS) and evidence-based clinical edits to ensure proper handling of claims.

K. Claim Submission

Molina Healthcare requires that all professional claims are submitted on a CMS-1500 Form, and all technical/facility claims are submitted on a UB-04 Form with the National Provider Identifier (NPI). Please refer to Section H for additional information regarding NPI. Both of these forms are available via the links below:

- **CMS 1500 Form**
- **UB 04 Form**

L Members Held Financially Harmless

The practitioner/provider will not seek to collect, accept payment from, or bill Molina Healthcare Members any amounts except applicable co-payments or coinsurance for the provision of covered services over and above those paid for by Molina Healthcare.

Practitioners/providers who participate in Medicaid agree to accept the amount paid as payment in full (see 42 C RF 447.15) with the exception of co-payment amounts required in certain Medicaid categories (Native Americans are exempt from co-payment requirements).

Aside from co-payments, a provider may not bill a Member for any unpaid portion of the bill or for a claim that is not paid with the following exceptions:

- **Failure to follow managed care policies:** A Member must be aware of the providers, pharmacies, facilities and hospitals, who are contracted with Molina Healthcare; or
- **Other Member responsibilities:** 1) The Member has been advised by the provider that the service is not a covered benefit; 2) The Member has been advised by the provider that he/she is not contracted with Molina Healthcare; and/or 3) The Member agrees in writing to have the service provided with full knowledge that he/she is financially responsible for payment.

M. Enhanced Payments for Primary Care Services

Molina Healthcare will reimburse physicians with a specialty designation of family medicine, general internal medicine, or pediatric medicine at a rate not less than 100 percent of the payment rate that applies to such services under Medicare.

N. EDI Payer ID: New Mexico Clearing House Information:

Name	Phone Number	Transaction Type/Format	Payer ID
Emdeon	**(800) 296-3736**	**CMS 1500 - Professional (837P) UB 92 - I Eligibility Inquiry/Response (270/271) Cla**	**09824**

The Companion Guide and other EDI information can be obtained on the website: Molina Healthcare EDI Information and Materials

O. Electronic Remittance Advice (ERA)

Molina Healthcare offers EFT/ERA free to our practitioners/providers through Provider Net Portal. Registration is easy. Contact your dedicated Molina Healthcare Provider Service Representative if you are unable to register.

P. Overpayments

Practitioners/providers are required to report overpayments to Molina Healthcare by the later of the date which is sixty (60) calendar days after the date on which the overpayment was identified or the date any corresponding cost report is due, if applicable. A person has identified an overpayment if the person has actual knowledge of the existence of an overpayment or acts in reckless disregard or with deliberate indifference of the overpayment.

1. Self-Reporting

Within sixty (60) calendar days from the date on which the practitioner/provider identifies an overpayment, the practitioner / provider must send an "Overpayment Report" to the CONTRACTOR and HSD, which must include:

a. Provider's name;
b. Provider's tax identification number and National Provider Number;
c. How the overpayment was discovered;
d. The reason for the overpayment;
e. The health insurance claim number, as appropriate;
f. Date(s) of service;
g. Medicaid claim control number, as appropriate;
h. Description of a corrective action plan to ensure the Overpayment does not occur again;
i. Whether the Provider has a corporate integrity agreement (CIA) with the United States Health and Human Services Department Office of Inspector General (OIG) or is under the OIG Self-Disclosure Protocol;
j. The specific dates (or time-span) within which the problem existed that cause the overpayments;
k. If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment; and
l. The refund amount.

2. Refunds

All self-reported refunds for overpayments must be made by the provider to Molina Healthcare as an intermediary and are the property of Molina Healthcare unless HSD, the Recovery Audit Contractor or Medical Fraud and Elder Abuse Division (of the New Mexico Attorney General's Office) independently notified the Provider that an overpayment existed or Molina Healthcare fails to initiate recovery within twelve (12) months from the date the CONTRACTOR first paid the claim; or fails to complete the recovery within fifteen (15) months from the date the it first paid the claim. In cases where HSD, the RAC, or MFEAD identifies the overpayment, HSD will seek recovery of the Overpayment in accordance with NMAC §8.351.2.13.

The provider may:

a. request that Molina Healthcare permit installment payments of the Refund, such request be agreed to by Molina Healthcare and the Provider; or
b. in cases where HSD, the RAC, or MFEAD identify the Overpayment, HSD will seek recovery of the Overpayment in accordance with NMAC §8.351.2.13.

3. **Failure to Self-Report and/or Refund Overpayments**
   Overpayments that have been identified by the Provider and not self-reported within the sixty (60)-day timeframe are presumed to be false claims and are subject to referrals as Credible Allegations of Fraud.

Q. Health Care Acquired Conditions (HCAC) and Never Events

Molina Healthcare has an established and systematic process to identify, investigate and review any Quality of Care, Adverse Event/Never Event, and/or service issues affecting Member care. This process includes researching the issue, resolution of the issue, and tracking facilities and providers for trend issues. Confirmed Adverse Events/Never Events are reported to Molina Healthcare's Professional Review Committee for recommendations and/or case closure. If it is determined that a HAC has occurred, payment will be denied. In such instances, please note that the provider is not allowed to bill the Member.

R. Barred from Participation

Molina Healthcare will not make payment to any practitioner/provider who has been barred from participation based on existing Medicare, Medicaid or State Children's Health Insurance Program sanctions, except for Emergency Services.

S. Reimbursement for Members Who Disenroll While Hospitalized

If a Member is hospitalized at the time of enrollment or disenrollment from an MCO or upon an approved switch to another Centennial Care MCO, the originating MCO is responsible for payment of all covered inpatient facility and professional services provided within a licensed acute care facility, or a non-psychiatric specialty unit or hospitals until the date of discharge. Upon discharge, the Member becomes the financial responsibility of the MCO receiving the capitation payment for that Member.

If a Member is hospitalized and is disenrolled from an MCO due to a loss in Medicaid coverage, the MCO is only financially liable for the inpatient hospitalization and associated professional services until such time that the Member is determined to be ineligible for Medicaid.

If a Member is in a Nursing Facility at the time of disenrollment (not including loss of Medicaid eligibility), Molina Healthcare be responsible for the payment of all Covered Services until the date of discharge or the date of disenrollment, whichever occurs first.

Section 17 – Member Advocacy - Grievance, Appeal and Fair Hearing Process

This section describes the process to be utilized by practitioners/providers **who are assisting** Members with complaints and appeals, as well as for providers who are themselves filing a complaint or appeal on their own behalf. The processes for Members will be discussed first.

- A **complaint (also known as a grievance)** is any dissatisfaction voiced by any Member on any aspect of his/her health care or health benefits plan *other* than a request for services;
- An **appeal** is a request for review of a denied specific health care service or non-payment for a health care service;
- Complaints and appeals are reviewed and resolved to promote Member satisfaction and in compliance with applicable state and federal law, regulations and guidelines. Complaints are processed in a confidential manner. Molina Healthcare employees are required to sign a confidentiality statement at the time of hire; and
- No person will be subject to retaliatory action by Molina Healthcare for any reason related to complaints or appeals.

A. Assisting Molina Healthcare Members When They Have a Complaint or Appeal

When practitioners/providers are trying to help a patient get a service covered, or have a complaint or appeal addressed, Molina Healthcare Member complaint or appeal processes apply. The Member may select someone of his/her choosing, including an attorney (at the Member's expense), to represent his/her complaint or appeal. If someone other than the Member files a complaint on the Member's behalf, an authorization to represent the Member must be submitted to Molina Healthcare. ***If you are filing the complaint or appeal on behalf of a Member, you must submit a signed authorization form from the Member before Molina Healthcare can accept the complaint or appeal request. This authorization form can be found by following this link:*** **Authorization of Release - Appointment of Representative**

If you receive a complaint or an issue from a Molina Healthcare Member, please ask the Member to contact the Molina Healthcare Member Services Department. If a Member is unable to call Molina Healthcare for any reason, we ask that you take the basic information about the complaint or appeal from the Member. A form for written complaints or appeals is included in this section for your convenience. Upon filling out the form, providers can either call in the information to Molina Healthcare, or the information may be sent via mail or fax to the attention of the Appeals Department at the address or fax number listed in this section.

The Member, the legal guardian of the Member, in the case of minors or incapacitated adults, the Member's provider, or the representative of the Member with the Member's written consent, has the right to file a written or oral complaint or appeal to Molina Healthcare or to the Human Services Department (HSD) Hearings Bureau on behalf of the Member. This information is also provided to Members in the Member Handbook. As previously discussed, if you are filing the complaint or appeal on behalf of the Member, you must submit a signed authorization form from the Member before Molina Healthcare can accept the complaint or appeal request. A copy of that

form is included in this section for your convenience.

B. Filing a Formal Verbal or Written Complaint or Appeal for Members

Molina Healthcare's Appeals Department for Members is also known internally as the Member Advocacy Department. The Member or representative of the Member (with the Member's written consent) has the right to file a formal verbal or written complaint or appeal if they are dissatisfied with some aspect of Molina Healthcare (i.e., provider, or health care received or requested and not received).

A Complaint/Grievance may be filed orally or in writing within thirty (30) days of the date of the event causing the dissatisfaction. A Member or their representative may file an appeal of a Molina Healthcare action within ninety (90) calendar days of receiving Molina Healthcare's notice of action, i.e. denial. Oral inquiries from Members seeking to appeal an action are treated as Appeals in order to establish the earliest filing date for the Appeal. Molina Healthcare accepts, investigates and provides a written resolution to all oral appeal requests. An oral appeal must be followed by a written appeal that is signed by the Member within thirteen (13) calendar days. Failure to file the written appeal within thirteen (13) calendar days will constitute withdrawal of the appeal. Molina Healthcare will make its best efforts to assist the Member as needed with the written appeal.

A network provider also has the right to file a formal verbal or written appeal with Molina Healthcare, on the Member's behalf with the Member's written consent, if he/she is dissatisfied with Molina Healthcare's decision to terminate, suspend, reduce, or not provide services to a Member.

To submit a formal verbal or written complaint or appeal on behalf of a Molina Healthcare Member, call or write to:

Molina Healthcare of New Mexico, Inc.
Albuquerque: (505) 342-4681
Toll free: (800) 580-2811

Molina Healthcare of New Mexico, Inc.
Attn: Appeals Department
P.O. Box 3887
Albuquerque, NM 87190-9859
Fax (in Albuquerque): (505) 342-0583

Basic information needed when initiating a formal verbal or written complaint or appeal on behalf of a Member:

- Member name;
- The Member's Molina Healthcare identification number;
- Telephone number (where Member can be reached during the day); and
- A brief description of the issue(s).

All formal verbal or written complaints and appeals are to be reported to Molina Healthcare who relies on the assistance of providers in facilitating the notification process as well as helping to

resolve the Member's issues as quickly as possible. If a provider or someone other than the Member files a formal verbal or written complaint or appeal on any Member's behalf, an authorization to represent that Member must be submitted to Molina Healthcare.

When practitioners/providers assist a Molina Healthcare Member in trying to get a service covered, or a formal verbal or written complaint or appeal addressed, Molina Healthcare Member complaints and appeal processes apply. At any level of the formal verbal or written complaint and appeal process, the Member can select someone of his/her own choosing to represent him/her. This includes the legal guardian of the Member in the case of a minor or incapacitated adult, providers working on behalf of the Member with the Member's written permission, and/or an attorney (at the Member's expense) to represent him/her.

Please contact Molina Healthcare if any Member needs the complaint and appeal information in a language other than English. Translation Services and Teletype/ Telecommunication Device for the Deaf (TTY/TDD) services for the hearing impaired are also available.

C. Accessing TTY/TDD Services

Our Complaint and Appeal Line is accessible to all Members. Deaf, hard of hearing, or speech-disabled Members can communicate with Molina Healthcare through the Relay New Mexico (Relay NM) Network. This service is available twenty-four (24) hours a day, seven (7) days a week. Members may access Relay NM by following these directions:

- Using your TTY text telephone, call the Relay NM operator **toll free at (800) 659-8331**;
- Type your message to the Relay NM operator, informing him/her that you would like to contact the Molina Healthcare Member Services Department in **Albuquerque at (505) 341-7493 or toll free at (888) 825-9266;**
- The Relay NM operator voices the typed conversation to the Molina Healthcare Member Service Representative answering the call;
- The Member Service Representative can converse with the Member through the Relay NM operator, who then types the verbal communication to the Member; or
- Molina Healthcare Appeals Staff can also contact Members using the TTY text telephone by calling Relay NM **toll free at (800) 659-1779**, and asking the Relay NM Operator to call the Member and type the conversation to the Member.

Conversations are kept confidential by Molina Healthcare and Relay NM. Relay NM does not maintain records of actual conversations.

D. Expedited Review Processes

Internal expedited reviews on pre-service denials will be completed for all Members in accordance with the medical urgency of the case and will not exceed seventy-two (72) hours whenever:

- The life or health of a covered person may be jeopardized; and
- The covered person's ability to attain, maintain or regain maximum function may be jeopardized.

Such determination is based on:

- A request from the Member;
- A practitioner/provider's support of the Member's request;
- A practitioner/provider's request on behalf of the Member; or
- Molina Healthcare's independent determination.

If the expedited review request is denied, the Member and the practitioner/provider are notified and the review is placed in the standard review timeframe.

Automatic Appeals – In accordance with Medical Assistance Division Policy**, if a Member is inpatient and coverage for additional days is denied based on medical necessity, and if the conditions are met for an expedited appeal, Molina will automatically initiate an expedited appeal on behalf of the Member.**

E. Processing Member Formal Complaints and Appeals

Molina Healthcare provides to the Member and/or his/her representative, the opportunity before and during the appeal process, to examine the case file, including medical records and other documents and records considered during the appeal process that are not considered as confidential or privileged information. Molina Healthcare will include as parties to the complaint or appeal, the Member and his/her representative, or the legal representative of a deceased Member's estate.

- The complaint or appeal will be reviewed by a committee of one or more Molina Healthcare employees, who did not participate in any previous level of review or decision-making, including staff with expertise in the issue(s) under review; and
- When resolved, the Appeals Staff will inform the Member of the outcome of the review by letter. If the Member is dissatisfied with the resolution, he/she may appeal the decision with Molina Healthcare. If dissatisfied with an appeal outcome, the Member may also appeal to HSD and request a Fair Hearing.

The written decision will include the following:

- The results of the complaint or appeal review;
- The date the review of the complaint or appeal was completed;
- All information considered in investigating the complaint or appeal;
- Findings and conclusions reached based on the investigation results; and
- Disposition of the complaint or appeal.

If a denial has been upheld in whole or in part, the following information will also be provided:

- Information regarding the fact that the Member may, with a written request, receive reasonable access to and copies of all documents relevant to the appeal as allowed by law;
- Information on the Member's right to request a Fair Hearing to appeal the decision to the HSD Hearings Bureau within thirty (30) calendar days of the decision;
- The right to request the continuation of benefits while the hearing is pending, and how to make this request; and
- A statement that the Member may be held liable for the cost of those appealed benefits if the hearing decision upholds Molina Healthcare's original decision/action.

F. Requesting a Fair Hearing for Members

Members may request a Fair Hearing with HSD **after the appeals process has been exhausted with Molina Healthcare:**

Hearings Bureau
P.O. Box 2348
Santa Fe, NM 87504-2348
Santa Fe: (505) 476-6213
Toll free: (800) 432-6217, option #6
Fax: (505) 476-6215

When the HSD receives a request for a Fair Hearing to appeal Molina Healthcare's final decision, an official record of the appeal and copy of Molina Healthcare's final decision will be submitted to the HSD Hearings Bureau.

G. Continuation of Benefits While Awaiting the HSD Fair Hearing

Molina Healthcare will continue the Member's benefits while the appeal and/or HSD Fair Hearing process is pending.
The Member will be responsible for repayment of services provided to the Member if the Fair Hearing decision is not in the Member's favor.

Molina Healthcare will provide benefits until one of the following occurs:

- The Member withdraws the appeal;
- An HSD Administrative Law Judge issues a hearing decision adverse to the Member; and
- The time period of service limits of a previously authorized service has expired.

If the final resolution of the appeal is adverse to the Member, Molina Healthcare may recover the cost of the services furnished to the Member while the appeal was pending to the extent that services were furnished solely because of the benefit continuation requirement.

If Molina Healthcare or an HSD Administrative Law Judge reverses a decision to deny, limit, or delay services, and:

- The Member did not receive the disputed services while the appeal was pending, Molina Healthcare will authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires; and
- If the Member received the disputed services while the appeal was pending.

H. Time Limitations

Processing of complaints and appeals for Members must be completed within thirty (30) calendar days from the date a written or verbal complaint or appeal request is received. If a delay is incurred, the Member will be notified prior to the thirtieth (30^{th}) day. Molina Healthcare may extend the thirty (30) day timeframe by fourteen (14) calendar days if the Member requests the extension, or it is demonstrated to HSD that there is need for additional information, and the extension is in the Member's best interest.

A formal Member complaint or appeal request must be filed within ninety (90) calendar days of the date of Molina Healthcare's notice of action or the date the dissatisfaction occurred.

Timelines for Member Appeals

Complaint or Appeal Type	When Applied	Timelines
Expedited Resolution of Appeal Request	When taking the time for a standard resolution could seriously jeopardize the Member's life or health.	➢ 72 hours Oral decision notice ➢ **2 calendar days from the date of the oral decision notice** - Written decision notice
Denial for an expedited resolution request	When the request for an expedited resolution does not meet expedited review guidelines.	➢ **2 calendar days** - Written confirmation and a reasonable effort to provide verbal notice ➢ **30 calendar days** - To resolve the issue
Automatic Appeal	When an expedited service authorization rendered by Molina Healthcare denies or authorizes a service in an amount, duration, or scope less than was requested by the provider.	➢ **72 hours** - Written decision notice and best effort to provide oral decision notice.
Oral or Written pre or post service Appeal	When a Member makes an oral or written inquiry seeking to Appeal an action, the inquiry is treated as an Appeal, pre or post service.	➢ **5 business days** - Acknowledgement is sent to the Member after receipt of the request
Review Extension	When the Member requests the extension or Molina Healthcare can demonstrate the need for additional information.	➢ **14 calendar days** - To resolve. ➢ **2 business days** - Written confirmation of reason for extension when Molina Healthcare requests the extension.
Filing limit	Applies to timeframe that an Appeal is considered.	➢ **90 calendar days** - From date of occurrence or notice of action.
Appeal Files	Applies to timeframe that Appeal files are retained.	➢ **10 years** - From final decision date.

Section 18 - Provider Grievance, Reconsideration and Appeal Processes

Molina Healthcare ensures that providers may bring to its attention their concerns regarding the operation of the plan, reimbursement disputes, claims denials due to lack of prior authorization, timeliness issues, concerns regarding quality of and access to health care services, the choice of health care providers and the adequacy of the contracted network.

Provider concerns addressed here are specific to provider interests (as opposed to individual Member interests or provider issues initiated on behalf of a Member). Provider grievances and appeals are evaluated in a consistent, impartial and timely manner to ensure compliance with state and federal laws, regulations and standards.

A. Provider Grievances may be submitted orally by telephone, via email or in writing. **Providers may generate a grievance by calling the Molina Healthcare Member Services Department during regular business hours:**

Albuquerque: (505) 341-7493
Toll free: (888) 825-9266

Written complaints must be submitted by mail or fax to:
Molina Healthcare of New Mexico, Inc.
Attn: Appeals Department
P.O. Box 3887
Albuquerque, NM 87190-9859
Fax: (505) 342-0583

B. Grievances may be submitted for such things as a complaint about a Molina Healthcare Member or employee or about the health plan. Issues that are not related to a Molina Healthcare action are not eligible for appeal. Every effort will be made to resolve grievances at an informal level to the provider's satisfaction whenever possible.

C. Initial disputes/disagreements with claim payments/denial, except as noted below in #4, are handled as **a Provider Reconsideration Request (PRR**) and not considered formal appeals. (Please see the PRR Form at the end of this Section.) Examples of PRRs include:

- Disagreement with payment amount or denial of a claim; and/or;
- Claim edit disputes.

D. Those items that are handled as **Formal Appeals** include:

- Denial of a claim due to a Utilization Management decision (denial of prior authorization); and/or;
- Disagreement with a PRR decision.

E. Appeals must be submitted in writing to Molina Healthcare for Utilization Management issues (e.g. denials resulting from not obtaining prior authorization for some or all types of services and/or for all dates of service), and for Provider Reconsideration Requests (PRR) denials.

F. Registering and responding to provider grievances and appeals is performed by a member of the Appeals Department (also known internally at Molina Healthcare as the "Provider Inquiry, Research and Resolution" staff). The activities involved in registering and responding to provider grievances or appeals include the following:

- Notification of the review results in writing within thirty (30) calendar days;
- Documenting the substance of the grievance or appeal and the actions taken;
- Coordinating appeal reviews with the applicable department representative(s) responsible for the particular service(s) that are the subject of the grievance or appeal; and
- Notification to the provider of the appeal disposition.

G. The Appeals Department coordinates relaying provider grievance and appeal information to internal quality improvement committees.

H. Written notifications to the provider of appeal review determination decisions will include the following elements:

- The names and titles of the reviewers;
- A statement of the reviewer's understanding of the nature of the appeal and all pertinent facts;
- Reference to the evidence or documentation considered by the reviewer(s) in making the decision as applicable; and
- An explanation of the rationale for the reviewer's decision.

Timeline Grid

Type	Timeline
Complaints and Grievances	• Filing Limit: Ninety (90) calendar days from the date of dissatisfaction. • Resolution: No more than thirty (30) calendar days from receipt.
Appeals	• Filing Limit: Ninety (90) calendar days from the date of notice of action. • Resolution: Thirty (30) calendar days from receipt.

I. Appeal Process - When a provider appeal is submitted in writing to Molina Healthcare, the resolution of the appeal will include the following:

- The Appeals Department staff member assigned to the appeal will coordinate and document the investigation of the substance of the appeal;
- Molina Healthcare will appoint one or more persons responsible for the substantive area addressed by the concern to review the appeal and will grant the reviewers the authorization to take appropriate corrective action on the issue;
- The provider is encouraged to present additional data pertinent to the appeal, including but

not limited to, written materials, medical records and medical literature; and

- The Appeals Department will mail a written decision from the internal review to the provider within thirty calendar (30) days from the date the appeal is received.

J. Confidential Information

- When reviewing grievances and appeals, Molina Healthcare will treat all identifying information of Members in accordance with the rules and regulations of the Health Insurance Portability and Accountability Act (HIPAA), except as otherwise provided by State law and internal policy and procedure;
- To ensure confidentiality, information needed for a grievance or appeal review is available to Molina Healthcare staff member(s) who have a business need for the information, as required by HIPAA Minimum Necessary Rule guidance. In most cases, access is limited only to those staff members who are conducting the review.

K. The provider will not be subject to retaliation for filing a grievance or appeal.

L. Upon receipt, the issue is reviewed by the Appeals staff and the grievance or appeal is processed accordingly.

M. Molina Healthcare will maintain confidential **locked files** located in the Appeals Department, or secure electronic files, for all issues received.

N. Each file will identify and/or contain:

- Date the grievance or appeal was received;
- The name and address of the provider;
- The name of the person requesting the grievance or appeal or the name of the person on whose behalf the issue is being opened;
- The line of business under which the provider is contracted;
- Name of the staff member assigned to the issue;
- A description of the issue;
- Grievance or appeal type/level;
- Name of reviewer(s) and the final outcome;
- The date the issue was resolved and the date the provider was notified of the outcome; and
- Grievance and appeal files will be maintained for a period of no less than ten (10) years.

O. Reporting of Provider Complaints and Appeals

Provider complaints and appeals are reported to Molina Healthcare's governing body, the Board of Directors, through the Member and Provider Satisfaction Committee (MPSC) on a semi-annual basis. Complaint and appeal data is reported to HSD/MAD.

P. Provider Reconsideration Request Form

Please use the Molina Healthcare Provider Reconsideration Review Request (PRR) Form when submitting a claim adjustment request. This form can be accessed via the Molina Provider Portal by following this link: **PRR Form**

- A PRR Form is required for each claim;
- This form must be completely filled out, or it will be returned;
- Attach a legible copy of the claim and remittance advice;
- Upon receipt of this form and additional necessary information, the request will be reviewed and sent for processing if appropriate;
- If the request is declined, a letter will be sent with the denial reason;
- If you disagree with the PRR denial, you will have ninety (90) days from the date of the denial letter to appeal; and
- Mail the PRR Form (faxes will not be accepted) and the necessary attachments to:

Molina Healthcare of New Mexico, Inc.
P.O. Box 3887
Albuquerque, NM 87190-9859 Attention: Provider Services

If you have any questions or need additional copies of the PRR Form, please contact Member Services in **Albuquerque at (505) 341-7493 or** t**oll free at (888) 825-9266** and a representative will be glad to assist you.

Section 19 – Quality Improvement Program

Additional information on the Quality Improvement Program (QIP) and activities is available on our website at www.molinahealthcare.com

Upon request in writing, Molina Healthcare of New Mexico, Inc. (Molina Healthcare) will provide information on these or other QIP activities in writing, including a description of the QIP and an update on Molina Healthcare's progress in meeting the QIP goals. Please contact the QI Department in **Albuquerque at (505) 342-4660, extension 182618 or toll free at (800) 377-9594, extension 182618.**

For additional Health Improvement or program information, contact the Health Improvement Hotline in **Albuquerque at (505) 342-4660, extension 182618 or toll free at (800) 377-9594, extension 182618.**

A. Quality Improvement (QI)

The Molina Healthcare QIP is a comprehensive framework for continuous assessment and focused improvement of all aspects of health care delivery and service.

Program Philosophy

Molina Healthcare maintains the following values, assumptions, and operating principles for the Quality Improvement Program:

- The QIP provides a structure for promoting and achieving excellence in all areas through Continuous Quality Improvement (CQI);
- Improvements are based on industry "best practice" or on standards set by regulators or accrediting organizations;
- The QIP is applicable to all disciplines comprising the health plan, at all levels of the organization;
- Teams and teamwork are essential to the improvement of care and services;
- Data collection and analysis is critical to problem-solving and process improvement;
- Each employee is highly valued as a contributor to quality processes and outcomes;
- Compliance with National Committee for Quality Assurance (NCQA) Standards and achievement of accreditation demonstrates Molina Healthcare's commitment to continuous quality improvement (CQI); and
- Information about the QIP is available for Members and providers upon request.

B. Quality Improvement Program Goals

Molina Healthcare has defined the following goals for the QIP:

- Design and maintain programs that improve the care and service outcomes and ensure patient safety within identified Member populations, ensuring the relevancy through understanding of the health plan's demographics and epidemiological data;
- Define, demonstrate and communicate the organization-wide commitment to and involvement in achieving improvement in the quality of care, Member safety and service;
- Improve the quality, safety, appropriateness, availability, accessibility, coordination and continuity of the health care and service provided to Members;

- Promote Member safety through appropriate safety and error avoidance initiatives.
- Through ongoing and systematic monitoring, interventions and evaluation improve Molina Healthcare structure, process and outcomes;
- Using feedback from stakeholders, improve reporting methods to enhance the availability of relevant and timely information;
- Use a multidisciplinary committee structure to facilitate the achievement of QI goals, improve organizational communication and ensure participation of contracted community practitioners in clinical aspects of programs and services;
- Apply sound approaches and methods in the development of indicators that are objective and clearly defined using a systematic collection of valid and reliable data reported at the contract and plan level;
- Facilitate organizational efforts to achieve, maintain, and enhance regulatory compliance, including NCQA accreditation and to continually review practices to ensure compliance with standards and contractual requirements;
- Provide data on quality and outcomes to enable Medicare beneficiaries to compare and select from among health coverage options;
- Facilitate organizational efforts to sustain Centers for Medicare and Medicaid Services (CMS), Federal and State regulatory compliance;
- Promote and collaborate with the strategic healthcare entities in the development and implementation of Patient Centered Medical Homes and Health Home initiatives;
- Ensure systems are in place to address the cultural and linguistic diversity found within Molina Healthcare's Membership; and
- Ensure systems are in place to address the complex health needs found within Molina Healthcare's Membership.

The Program operates using the CQI process by:
- Continuously monitoring performance according to, or in comparison with objective, measurable performance standards—National, Regional or Local/Plan;
- Analyzing information and data to identify trends;
- Prioritizing opportunities for improvement;
- Designing interventions for improvement;
- Implementing those interventions;
- Re-measuring the processes; and
- Evaluating the effectiveness of the interventions and identifying additional opportunities for improvement.

The purpose and scope of the QIP is to provide a formal process to monitor and evaluate the quality, utilization, appropriateness, safety, efficiency and effectiveness of care and service delivered to Molina Healthcare Members using a multidimensional approach. This approach enables the organization to focus on opportunities for improving operational processes as well as health outcomes and Member and provider satisfaction. The QIP promotes and fosters accountability of employees and network affiliated health personnel for the quality and safety of care and services provided to Molina Healthcare Members.

The major areas of emphasis of the QIP are, in no specific order:
- Delegation;

- Patient Safety;
- Collaborative Activities;
- Medical Record Review;
- Quality of Care Review;
- QIP Surveys;
- Member Satisfaction Assessment;
- Clinical and Preventive Data Assessment;
- Health Management;
- Health Promotion and Education;
- Cultural Competency/Sensitivity;
- Complex Health Needs;
- Credentialing and Recredentialing; and
- Regulatory Compliance.

Contracted practitioners/providers must allow Molina Healthcare to use its performance data collected in accordance with the practitioner/provider'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.

Molina Healthcare welcomes and encourages practitioner/provider participation in the Molina Healthcare QIP. If you have any interest in doing so, have feedback, or questions in general, please contact us toll free at (800) 377-9594, extension 182618.

C. Patient Safety Program

Molina Healthcare is committed to promoting and fostering an environment that ensures quality and safety of care and services provided to our Members. Molina Healthcare promotes safe health practices through education and dissemination of information for decision-making. Molina Healthcare does this in the following ways:

- Distributes information to Members for the purpose of helping him/her improve his/her knowledge of clinical safety in his/her own care;
- Collaborates with network providers to support safe clinical practices;
- Monitors and reviews codes specific to safety issues in the complaint system to capture, track and trend Member safety concerns;
- Develops and maintains drug usage criteria, assesses the efficacy of new drugs or a new use for an existing drug;
- Collaborates with the Molina Healthcare Pharmacy Benefits Manager to ensure that polypharmacy of narcotic controlled substances and drug interaction information is incorporated into routine counseling information provided to Members and practitioners/providers;
- Monitors indicators relating to polypharmacy of narcotic controlled substances and misuse of medication;
- Monitors Member complaint, appeal, and quality of care review and reporting processes for issues regarding poor care or potentially unsafe practices;
- Ensure review and action, through the expedited appeal process, on an appeal of a medical

necessity denial based on the urgency of the request;
- Promotes continuity and coordination of care between behavioral health and primary care practitioners (PCPs);
- Monitors processes to ensure that care is continued if a provider is terminated from or leaves the Molina Healthcare Network;
- Verifies the credentials of providers joining the Molina Healthcare Network to assure that they meet the requirements for providing quality care;
- Ensures that credentialing and recredentialing processes includes practice site assessment data, medical record review data, utilization and complaint information;
- Evaluates provider offices during site visits for initial credentialing or follow-up visits for other indications;
- Reviews Department of Health and Human Services Office of Inspector General sanctioning information; and
- Monitors Critical Incident reports on Molina members submitted through HSDs Critical Incident Management website to ensure Member Safety and Quality of Care services rendered to Members.

D. HEDIS® & CAHPS®

1. Measurement of Clinical and Service Quality

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

2. HEDIS®

Molina Healthcare utilizes NCQA HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is conducted annually in the spring. The data comes from on-site medical record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of health care aspects including immunizations, women's health screening, diabetes care, appropriate use of asthma medications, and prenatal and postpartum care. 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. These activities include Molina Healthcare's diabetic and asthma health management programs, childhood and adolescent well- child and immunization program, and prenatal and postpartum care programs.

Some of the key HEDIS® measures that Molina Healthcare collects data on includes but is not limited to:
- Childhood and Adolescent Immunizations;
- Breast and Cervical Cancer Screening;

- Use of appropriate Medications for People with Asthma;
- Appropriate Treatment for Children with Upper Respiratory Infection and Pharyngitis;
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis;
- Controlling High Blood Pressure;
- Cholesterol Management for Patients with Cardiovascular Conditions;
- Comprehensive Diabetes Screening (HbA1c testing, LDL-C screening, Nephropathy monitoring and Eye Exams);
- Medical Assistance with Smoking Cessation (Advising Smokers to Quit only);
- Use of Imaging Studies for Low Back Pain;
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD;
- Prenatal and Postpartum Care;
- Preventive Dental;
- Blood Lead Screening;
- Antidepressant Medication Management; and
- Follow-up After Hospitalization for Mental Illness.

Selected HEDIS® results are provided to HSD as part of our contract. Health plans also submit results directly to NCQA, consistent with the original intent of HEDIS® – to provide health care Members data with which to make informed decisions. The data is also used by NCQA to establish health plan performance benchmarks and is an integral part of the NCQA health plan accreditation process.

Molina Healthcare's most recent HEDIS® results can be found on our website at HEDIS and then click on HEDIS® Annual Trends.

Your office may be requested to submit documentation from medical files as part of the HEDIS® data collection process.

As part of our QIP, we look to our providers to assist with Molina Healthcare's HEDIS® process by accurately coding and documenting care and services. The administrative data for HEDIS® comes from submitted claims information. Providers also assist Molina Healthcare with the HEDIS® process by providing patient medical record information either by faxing or mailing information to Molina Healthcare, or by allowing our medical record reviewers to schedule a time to review records in the office. Medical record information is typically collected during February through May of each year. Molina Healthcare does cover some costs associated with copying and mailing medical records. The Molina Healthcare HEDIS® process is Health Insurance Portability and Accountability Act compliant where applicable.

HEDIS® Coding Guidance for Providers, Billers and Coders

Molina Healthcare understands that the annual HEDIS® audit process can be burdensome to our healthcare partners. We want to reduce this burden. Provider sites are strongly encouraged to utilize the Medicaid and HEDIS information that is available on the Molina Healthcare Provider Portal and through Provider Engagement

Team presentations. Electronic submission of health data on our membership with appropriate coding will reduce the need for hybrid chart abstraction.

3. CAHPS®

CAHPS® is the tool used by NCQA to summarize Member satisfaction with health care, including practitioners/providers and health plans. The CAHPS® surveys are administered annually in the spring to randomly selected Centennial Care adult Members, and Centennial Care child Members with chronic conditions.

CAHPS® survey 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 and health care Members to help ascertain the quality of services being delivered. This survey provides consumers, Members and health plans with information about a broad range of key consumer issues such as:

- Rating of Health Plan;
- Rating of Health Care;
- Getting Needed Care;
- Getting Care quickly;
- How Well Doctors Communicate;
- Customer Service;
- Share Decision Making;
- Health Promotion and Education;
- Coordination of Care;
- Rating of Personal Doctor;
- Rating of Specialist; and
- Effectiveness of Care Measures (relating to smoking cessation).

Molina Healthcare's most recent CAHPS® results can be found on our website at CAHPS and then click on CAH CAHPS® Annual Trends.