

2014

Provider Manual





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

Dear Practitioner/Provider:

I would like to extend a personal welcome to Molina Healthcare of New Mexico, Inc. (Molina Healthcare). This Provider Manual has been written specifically to address the requirements of delivering covered services to Molina Healthcare Members enrolled with Centennial Care.

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 will be revised as policies, program or regulatory requirements change. All changes and updates will be updated and posted to the Molina Medicare website as they occur. All contracted providers will receive an updated Provider Manual annually, which will be made available at www.MolinaHealthcare.com

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 look forward to supporting all your efforts to provide quality care.

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

Sincerely,

A handwritten signature in black ink that reads "Patty Kehoe".

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

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

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.

Company Profile

Molina Healthcare, Inc. (MHI) is a family-founded, physician-led managed care organization headquartered in Long Beach, California. In 2010, Molina Healthcare was named the largest Hispanic-owned company in the U.S. Founded more than thirty years ago; MHI has grown to serve more than 1.8 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.

Introduction to the Network Management and Operations Department

The Network Management and Operations Department (NM&O) is devoted exclusively to the needs of contracted providers. Within this department are five (5) major functions:

- **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 Network Administration / Provider Information and Data Management.** The staff in this area continuously corrects demographic data, contract affiliations and system configuration in order to communicate and pay providers in a timely manner based on their configuration within Molina Healthcare’s databases.
- **Provider and Member Inquiry, Research and Resolution (Appeals).** This area addresses Members’ appeals and grievances and Provider appeals, grievances and reconsideration processes regarding claims payments and/or denials.
- **Training and Communication.** The trainers in this department work in conjunction with Provider Services to educate and train providers about their rights and responsibilities under Molina Healthcare’s government-sponsored programs such as Medicaid/Centennial Care and Medicare.

- **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.

[Provider Service Representative Territory Grid](#)

Section 2 – Contact Information for Providers

Location

Molina Healthcare of New Mexico, Inc.
 8801 Horizon Blvd. NE, Ste. 400
 Albuquerque, NM 87113

Correspondence

(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		
	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)		
	Albuquerque Toll Free Phone	(505) 342-4663 (800) 723-7762
Services available in English and Spanish	English Telephone Spanish Telephone Hearing Impaired (TTY/TDD)	Toll Free (888) 275-8750 Toll Free (866) 648-3537 Toll Free (800) 659-8331 or dial 711
Claims and Claims Appeals		
Provider Customer Services Paper Claims: Molina Healthcare of New Mexico, Inc. P.O. Box 22801 Long Beach, CA 90801	Albuquerque Toll Free Phone Fax Spanish Hearing Impaired	(505) 341-7493 (888) 825-9266 (505) 342-0595 (866) 648-3537 (800) 659-8331 or dial 711

To overnight claims: Molina Healthcare of New Mexico, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802-4317	(TTY/TDD)	
Compliance / Anti-Fraud Hotline (24 hours a day/7 days a week)		
Confidential Compliance Official 8801 Horizon Blvd NE Albuquerque, NM 87113	Toll Free Weblink	Molina Healthcare AlertLine at: (866) 606-3889 Molina Healthcare Fraud Alert
Complex Medical Care Management / Care Coordination Review		
	Toll Free Phone Toll Free Fax	(800)377-9594 extension 181120 (866) 472-4575
Credentialing		
Molina Healthcare of New Mexico, Inc. Credentialing Department 8801 Horizon Blvd NE Suite 400 Albuquerque, NM 87113	Toll Free Phone Fax	(800) 377-9594 (505) 798-7313
Dental Services		
Dental Services / DentaQuest Call Molina Healthcare Member Services	Albuquerque Toll Free Phone	(505) 341-7493 (888) 825-9266
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)		
	Albuquerque Toll Free Phone	(505) 342-4660 extension 182618 (800) 377-9594 extension 182618
Health Improvement Program		
	Albuquerque Toll Free Phone	(505) 342-4660 extension 182618 (800) 377-9594 extension 182618
Member Services / Provider Customer Services (for Member eligibility) 8:00 a.m. to 5:00 p.m.		
	Albuquerque Toll Free Phone Fax Spanish Nurse Spanish TTY/TDD	(505) 341-7493 (888) 825-9266 (505) 342-0595 (866) 648-3537 (866) 833-4703 (800) 659-8331 or dial 711

	Hearing Impaired (TTY/TDD)	
Prior Authorizations: 8:00a.m. -5:00 p.m.		
	Toll Free Phone Toll Free Fax	(877) 262-0187 (888) 802-5711
	Medicare Phone Medicare Fax	(888) 440-0127 (866) 450-3914
Pharmacy and Formulary		
	Toll Free Phone	(888)825-9266
Quality Improvement		
Molina Healthcare of New Mexico, Inc. Quality Improvement Department 8801 Horizon Blvd NE STE 400 Albuquerque, NM 87113	Toll Free Phone Fax Toll Free Fax	(800) 377-9594 (505) 798-7315 (877) 553-6508
Transportation Services		
Integrated Transport Management (ITM)	Toll Free Phone	(888) 593-2052
Utilization Management, Referrals, and Authorization		
Molina Healthcare of New Mexico, Inc. Utilization Management 8801 Horizon Blvd NE STE 400 Albuquerque, NM 87113	Toll Free Phone Fax	(888) 665-1328 (888) 802-5711
Vision Services		
March Vision Services	Toll Free Phone	(888) 493-4070

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;

- 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:

- **Member Eligibility:**
 - Verify Members eligibility
 - Verify Member's benefits
- **PCP Information:**
 - Verify Member's PCP; and
 - Obtain PCP rosters.
- **Claims:**
 - Check claim status;
 - Submit CMS-1500 Claim Forms; and
 - Submit Provider Reconsideration Request (PRR) forms.
- **Prior Authorizations:**
 - Check prior authorization status; and
 - Submit prior authorization requests – Information about diagnosis and procedure codes is also readily available.
- **Provider Directory:**
 - Search for contracted providers by name, specialty or zip code;
- **Download Forms:**
 - Print and/or save to your computer forms most useful and frequently used (i.e. prior authorization request (medical and pharmacy), Provider reconsideration review forms, etc.); and
- **Change Mailing Address and Telephone Number.**

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 CAHP Scores;
- Provider Coding Tools;
- Preventive Health Guidelines; and
- Critical Incident Reporting.

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

Section 3 – Member Eligibility, Enrollment and Health Assessment

Member Eligibility

All individuals determined Medicaid eligible are required to participate in the Centennial Care Program unless specifically excluded by the 1115 Waiver. These are Recipients in the Developmental Disabilities 1915 c Home and Community-based Waiver or are Recipients with developmental disabilities in the Mi Via 1915 c Waiver.

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:

- Verification of Member eligibility;
- A Provider Directory;
- Primary Care Practitioner Selection Form;
- Member Handbook, which includes Member rights and responsibilities; and
- Notice of Privacy Practices.

Centennial Care Members enrolled with Molina Healthcare of New Mexico are provided with an identification card identifying the Member as a participant in the Centennial Care Program. These cards include:

- 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;
- Member co-payment amounts for covered services; and
- Expiration date (Member's eligibility review date for the next calendar year).

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

Front:

Member: JOHN A DOE		
Identification # 3333333333		
Date of Birth: 01/01/2001		
Coverage Effective date: 01/01/2014		
<hr/>		
PCP: Tom Kelly		
PCP Phone: (505) 888-7777		
PCP Address: 6000 First St Albuquerque, NM 87111		
Patient Responsibility:		
Office Visit	\$0.00	Emergency Room \$0.00
Hospital Inpatient	\$0.00	Urgent Care \$0.00
Prescriptions	\$0.00	
Issuer: 000M1808	RXBIN: 004336 RXPCN: ADV RXGRP: Rx0813	

Back:

Members: (505) 342-4681 (Albuquerque) or (800) 580-2811
Behavioral Health: (505) 342-4681 (Albuquerque) or (800) 580-2811
Long Term Care: (505) 342-4681 (Albuquerque) or (800) 580-2811
Self-Direction: (505) 342-4681 (Albuquerque) or (800) 580-2811
Pharmacy: (505) 342-4681 (Albuquerque) or (800) 580-2811
Transportation: (888) 593-2053
Nurse Advice Line: For English (888) 275-8750 or for Spanish (888) 648-3537
 For more information regarding Physical Health, Behavioral Health, and Long-Term Care Services, please contact **Member Services** at (505) 342-4681 (Albuquerque) or (800) 580-2811 (State-wide)


Emergency Services: Call 911 or go to the nearest emergency room

Providers: (505)341-7493 or (888)825-9266
 Claims Submission: PO Box 22801, Long Beach, CA 90801

www.molinahealthcare.com

Sample of Molina Healthcare of New Mexico Centennial Care ID Card – Alternative Benefit Plan

Front:

Member: JOHN A DOE	
Identification # 3333333333	Alternative Benefit Plan
Date of Birth: 01/01/2001	
Coverage Effective date: 01/01/2014	
<hr/>	
PCP: Tom Kelly	
PCP Phone: (505) 888-7777	
PCP Address: 6000 First St Albuquerque, NM 87111	
Patient Responsibility:	
Office Visit \$0.00	Emergency Room \$0.00
Hospital Inpatient \$0.00	Urgent Care \$0.00
Prescriptions \$0.00	
Issuer: 000M1808	RXBIN: 004336
	RXPCN: ADV
	RXGRP: Rx0813

Back:

Members: (505) 342-4681 (Albuquerque) or (800) 580-2811
Behavioral Health: (505) 342-4681 (Albuquerque) or (800) 580-2811
Long Term Care: (505) 342-4681 (Albuquerque) or (800) 580-2811
Self-Direction: (505) 342-4681 (Albuquerque) or (800) 580-2811
Pharmacy: (505) 342-4681 (Albuquerque) or (800) 580-2811
Transportation: (888) 593-2053
Nurse Advice Line: For English (888) 275-8750 or for Spanish (888) 648-3537
For more information regarding Physical Health, Behavioral Health, and Long-Term Care Services, please contact **Member Services** at (505) 342-4681 (Albuquerque) or (800) 580-2811 (State-wide)

Emergency Services: Call 911 or go to the nearest emergency room

Providers: (505)341-7493 or (888)825-9266
Claims Submission: PO Box 22801, Long Beach, CA 90801

www.molinahealthcare.com

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 on the Provider Web Portal.

PCP Assignment

At the time a Member is enrolled with Molina Healthcare, a primary care practitioner (PCP) is assigned to the Member with the exception of Dual Eligible Members. The Member will receive an identification card showing the assigned PCP.

Individual family Members may choose the same or different PCPs.

PCPs are chosen 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, complex behavioral health conditions or disabilities.

Change in PCP Assignment

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 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 (20th) of the month, it will become effective the first day of the following month. If the request is made after the twentieth (20th) day, it will become effective the first (1st) day of the second (2nd) month following the request.

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.

Molina Healthcare Initiated Change of PCP

Molina Healthcare may initiate a PCP change for a Member under the following circumstances:

- 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;
- A Member's PCP ceases to be a Molina-contracted practitioner;
- 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;
- A Member has initiated legal actions against the PCP; and/or
- The PCP is suspended for any reason.

PCP and Medical Practitioner and Pharmacy Lock-In

When concerns about misuse of prescription drugs by a Member are identified, Molina Healthcare may place a Member into "lock-in." Molina Healthcare utilizes the following to identify members eligible for PCP and medical provider and pharmacy lock-in including but not limited to: claims data showing recurrence of treatment for problems that may be inappropriate or improbable, emergency department reports, pharmacy and prescription reports, Care Coordination Referral Forms, provider feedback and grievances and Nurse Advice Line reports. Behaviors that may trigger placement into lock-in include, but are not limited to, excessive emergency department utilization, excessive PCP change requests, provider reports of drug demands when not medically indicated, non-compliance to treatment plans, self-referral to pain management providers and/or excessive "no-shows" to provider appointments.

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.

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

Pharmacy Lock-In

Molina Healthcare may also require that a Member be restricted to a single pharmacy provider when non-compliance or drug seeking behavior is suspected. Prior to placing the Member on pharmacy lock-in, Molina Healthcare will inform the Member and the Member's representative(s) of the intent to lock-in. The Member may choose which pharmacy is assigned. Molina Healthcare's Grievance procedure will be made available to any Member being designated for pharmacy lock-in.

The pharmacy lock-in will be reviewed and documented and reported to HSD every quarter. The Member will be removed from pharmacy lock-in when Molina has determined that the compliance issue or drug seeking behavior has been resolved and that the recurrence of the problems is judged to be improbable. HSD will be notified of all lock-in removals at the time they occur. HSD will be notified of all lock-in removals.

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.

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 payer 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.

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.

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.

Continuity of Care after Practitioner Termination

- 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;
- 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 State Children's Health Insurance Program sanctions (except for Emergency Services) or fraud reasons.

This continuity of care includes but is not limited to the following situations:

- Surgery follow-up as covered by the global surgical fee and until any operative or post-operative complication has resolved or ninety (90) have elapsed;
- Third (3rd) trimester pregnancies through the post-partum period; (newborns enrolled with Molina Healthcare must be treated by a contracted practitioner);
- Members in the midst of a course of chemotherapy or radiation may continue through the current course of treatment; or

- The treating practitioner has left the network and there is no similar practitioner in network however, these situations require Medical Director approval.

Member Notification of PCP and Specialist Termination

Molina Healthcare will notify the Member in writing of their PCP termination within thirty (30) calendar days of the receipt of the termination. 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.

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 Team is available to respond to questions regarding the Care Plan Monday through Friday from 8:00 a.m. – 5:00 p.m. Please call **toll free (855) 315-5677**.

To verify Member benefits or eligibility, please contact Member Services in **Albuquerque at (505) 341-7493** or **toll free at (888) 825-9266**.

Section 4 - Member Rights and Responsibilities

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

Member Rights

The Member and/or his or her legal guardian(s) have the right to:

1. Receive information about Molina Healthcare, Molina Healthcare's policies and procedures regarding products, services, its contracted providers, grievance procedures, benefits provided and Members' rights and responsibilities.
2. Be treated with courtesy and consideration, equitably and with respect and recognition of his/her dignity and right and need to for privacy.
3. Choose a PCP within the limits of the covered benefits, and plan network, and the right to refuse care of specific practitioners.
4. Receive from the Member's practitioner(s), in terms that the Member or legal guardian(s) understands, an explanation of his/her complete medical condition, and 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 will be provided to his/her next of kin, guardian, agent or surrogate, if available, and documented in the Member's medical record.
5. Receive health care services in a non-discriminatory fashion.
6. Participate with his/her health care practitioners in decision making in all aspects of his/her health care, including the treatment plan development, acceptable treatments and the right to refuse treatment.
7. Be provided with informed consent.
8. Choose a surrogate decision-maker to be involved as appropriate, to assist with care decisions.
9. Seek a second opinion by another provider in the Molina Healthcare's network when Members need additional information regarding recommended treatment or believe the provider is not authorizing requested care.
10. A candid discussion of appropriate or medically necessary treatment options for his/her conditions, regardless of cost or benefit coverage.
11. 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 HSD hearings process, at no cost, without fear of retaliation.
12. File a complaint, grievance or appeal with Molina Healthcare or, the HSD Hearings Bureau, for Medicaid Members, and to receive an answer to those complaints, grievances or appeals within a reasonable time.
13. Choose from among the available providers within the limits of Molina Healthcare's network and its referral and prior authorization requirements.
14. Make his/her 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.

15. Privacy of medical and financial records maintained by Molina Healthcare and its providers, in accordance with existing law.
16. Access the Member's medical records in accordance with the applicable federal and state laws and regulations.
17. Consent to or deny the release of identifiable medical or other information by Molina Healthcare, except when such release is required by law.
18. Request an amendment to his/her Protected Health Information (PHI) if the information is believed to be incomplete or wrong.
19. Receive information about Molina Healthcare, its health care services, how to access those services, the network providers (i.e., title, education, and the Patient Bill of Rights).
20. Be provided with information concerning Molina Healthcare's policies and procedures regarding products, services, providers, appeal procedures, obtaining consent for use of Member medical information, allowing Members access to his/her medical records, and protecting access to Member medical information, and other information about Molina Healthcare and benefits provided.
21. Know upon request of any financial arrangements or provisions between Molina Healthcare and its providers, which may restrict referral or treatment options or limit the services offered to the Members.
22. Be free from harassment by Molina Healthcare or its network providers about contractual disputes between Molina Healthcare and providers.
23. Available and accessible services when medically necessary as determined by the 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.
24. Adequate access to qualified health professionals near where the Member lives or work within the service area of Molina Healthcare.
25. Prompt notification of termination or changes in benefits, services or provider network.
26. 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.
27. Continue an ongoing course of treatment for a period of at least thirty (30) 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.
28. Make recommendations regarding the organization's Member rights and responsibilities policies.
29. 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.
30. Select an MCO and exercise switch enrollment rights without threats or harassment.
31. 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.
32. Be 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.

33. 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.
34. 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.

In addition:

35. Members who do not speak English as his/her first language have the right to access translator services at no cost for communication with Molina Healthcare.
36. Members who have a disability have the right to receive information in an alternative format in compliance with the Americans with Disabilities Act.
37. 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 Provider, or provided without required pre-authorization.

Member Responsibilities

Molina Healthcare enrolled Members and/or his or 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 outlined below:

Benefit Package	Services Included but not limited to:
Behavioral Health Services	Inpatient Behavioral Health, residential treatment center services, substance abuse services including outpatient and residential, treatment foster care I and II, Assertive Community Treatment (ACT), psychosocial rehabilitation services, behavior management skills development services, day treatment services, intensive outpatient programs, Behavioral Health professional outpatient services and value-added services.
Medical and Acute Care Services (Physical Health)	Ambulatory surgical center services, anesthesia services, audiology services for adults and children, care coordination services, cancer screening, diagnostic and treatment services, dental services, diagnostic imaging and therapeutic radiology, dialysis, durable medical equipment, EPSDT service package, emergency services, family planning services, hearing aids for adults and children, home health care, hospice, hospital services (inpatient and outpatient), infusion therapy, laboratory, nutritional counseling, occupational services, optometry, specialists, pharmacy, physical therapy, podiatry, preventive health, prosthetics/orthotics, short term nursing facility stays, speech and language therapy, transplants, transportation, vision and value-added services.
Home and Community Based Services (HCBS) Services	Adult day health, assisted living, emergency response services, environmental modifications, case management, homemaker services, private duty nursing, respite and maintenance therapies (physical, occupational and speech).
Long-Term Care Support Services:	Day health services, skilled nursing facility stays and personal care services.

Community Benefit

For Members meeting nursing facility level of care, Molina Healthcare provides the Community Benefit, as determined appropriate based on the 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 Care 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; and
- Skilled Maintenance Therapy Services.

Self-Directed Community Benefit Services

- Behavior Support Consultation;
- Emergency Response;
- Employment Supports;
- Environmental Modifications;
- Home Health Aide;
- Homemaker;
- Nutritional Counseling;
- Private Duty Nursing for Adults;
- Related Goods;
- Respite;
- Skilled Maintenance Therapy Services;
- Specialized Therapies; and
- Transportation (non-medical).

For additional information regarding the Centennial Care Community Benefit, please contact your Long Term Care Provider Services Representative toll free at (800) 377-9594.

Table of Centennial Care Covered Services

Services Included Under Centennial Care
Accredited Residential Treatment Center Services
Adaptive Skills Building (Autism)
Adult Day Health
Adult Psychological Rehabilitation Services
Ambulatory Surgical Center Services
Anesthesia Services
Assertive Community Treatment Services
Assisted Living
Behavior Support Consultation
Behavior Management Skills Development Services
Behavioral Health Professional Services: outpatient behavioral health and substance abuse services
Care Coordination
Case Management
Community Transition Services
Community Health Workers
Comprehensive Community Support Services
Day Treatment Services
Dental Services
Diagnostic Imaging and Therapeutic Radiology Services
Dialysis Services
Durable Medical Equipment and Supplies
Emergency Response
Emergency Services (including emergency room visits and psychiatric ER)
Employment Supports
Environmental Modifications
Experimental or Investigational Procedures, Technology or Non-Drug Therapies *
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
EPSDT Personal Care Services
EPSDT Private Duty Nursing
EPSDT Rehabilitation Services
Family Planning
Family Support
Federally Qualified Health Center Services
Hearing Aids and Related Evaluations
Home Health Aide
Home Health Services
Homemaker
Hospice Services
Hospital Inpatient (including Detoxification services)
Hospital Outpatient
Indian Health Services
Inpatient Hospitalization in Freestanding Psychiatric Hospitals
Intensive Outpatient Program Services
ICF/MR
IV Outpatient Services
Laboratory Services

Medical Services Providers
Medication Assisted Treatment for Opioid Dependence
Midwife Services
Multi-Systemic Therapy Services
Non-Accredited Residential Treatment Centers and Group Homes
Nursing Facility Services
Nutritional Counseling
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
Personal Care Services
Pharmacy Services
Physical Health Services
Physical Therapy
Physician Visits
Podiatry Services
Pregnancy Termination Procedures
Preventive Services
Private Duty Nursing for Adults
Prosthetics and Orthotics
Psychosocial Rehabilitation Services
Radiology Facilities
Recovery Services
Rehabilitation Option Services
Rehabilitation Services Providers
Related Goods
Reproductive Health Services
Respite
Rural Health Clinics Services
School-Based Services
Skilled Maintenance Therapy Services
Smoking Cessation Services
Specialized Therapies
Speech and Language Therapy
Swing Bed Hospital Services
Telehealth Services
Tot-to-Teen Health Checks
Transplant Services
Transportation Services (medical)
Transportation Services (non-medical)
Treatment Foster Care
Treatment Foster Care II
Vision Care Services

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

Alternative Benefit Plan (ABP)

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:

	<100% FPL	101-138% FPL
Premiums	0	0
Co-Pay for most Outpatient Services (Note: prohibited for certain services)	0	\$8.00
Prescription Drugs		
• Preferred	0	\$3.00
• Non-Preferred	0	\$8.00
Non-Emergency use of Emergency Department	0	\$8.00
Inpatient Hospital Admission	0	\$25.00
Cap on total cost sharing	0	5% of family income
Services may be denied for non-payment of cost-sharing	No	Yes

Co-payments will be assessed on some services. The following are examples of some of those services:

ABP - ABP COPAYMENTS	
APPLIES ONLY TO ABP RECIPIENTS WHO ARE 101% - 138% FPL	
<u>Service/Cost Share</u>	<u>Exemptions</u>
<p><u>PHARMACY COPAYMENT (101% - 138% FPL):</u></p> <p>\$4 per drug item</p> <p>See exemptions below, including exemptions for family planning, preventive services, and prenatal drug items and some Behavioral Health drugs.</p> <p>\$8 For a brand name drug when there is a less expensive therapeutically equivalent drug on the Molina Healthcare prescription drug list. Unless your doctor provides evidence that the alternative drug on the Molina Healthcare prescription drug list will be less effective or have greater adverse reactions.</p>	<p>EXEMPTIONS from copayments for ABP</p> <ol style="list-style-type: none"> 1. Native Americans 2. Services rendered by Indian Health Services (IHS), Tribal 638 facility, or Urban Indian Facility 3. Emergency services , see notes below. 4. Family planning services, including drugs, procedures, supplies, and devices 5. Hospice patients 6. Medicare Cross Over claims including claims from Medicare Advantage Plans 7. Pregnant women 8. Prenatal & postpartum care and deliveries, and prenatal drug items 9. Mental health (Behavioral Health) and substance abuse services, including psychotropic drug items (minor tranquilizers, sedatives, hypnotics and stimulants to treat attention deficit disorders

PHARMACY COPAYMENT (up to and including 100% FPL):

\$ 0 for drugs on the Molina Healthcare prescription drug list.

\$ 3 For a brand name drug when there is a less expensive therapeutically equivalent drug on the Molina Healthcare prescription drug list. Unless your doctor provides evidence that the alternative drug on the Molina Healthcare prescription drug list will be less effective or have greater adverse reactions.

NON-EMERGENCY USE OF THE EMERGENCY ROOM

\$ 8 For non-emergent use of ER (up to and including 150% FPL)

\$ 50 For non-emergent use of ER (greater than 150% FPL)

PRACTITIONER SERVICES COPAYMENTS:

\$ 0 Outpatient Visit to physician or other practitioner, dental visit, rehabilitative or habilitative therapy session. (up to and including 100% FPL).

\$8 Outpatient visit to physician or other practitioner, dental visit, rehabilitative or habilitative therapy session. (101% to 138% FPL)

This copayment applies in places of service such as offices, outpatient hospitals (other than emergency rooms), clinics, and urgent care centers. It is applied to the professional service (the doctors charges), not to any facility charge.

Practitioner services copayments do not apply to emergency room facility or emergency room professional charges because of the exemption for emergency services (See below).

HOSPITAL COPAYMENTS

\$0 inpatient admission - (up to and including 100% FPL).

\$ 25 inpatient admission – This copayment does not apply if you are being transferred from another hospital or if you are admitted through the

are not considered psychotropic medications for the purpose of this provision.)

10. All preventive services
11. Provider preventable conditions
12. When the maximum family out of pocket expense has been reached.
13. Emergency services

<p>emergency room (101% to 138% FPL).</p> <p>When the copayment is applied to an inpatient service, the copayment is always applied to the hospital's facility charge, not the doctor's charge.</p>	
<p><u>Emergency Services Exemption for Above ABP Copayments</u></p> <ul style="list-style-type: none"> ▪ The ABP copayments do not apply when treatment is for an “exempt emergency service” as described in the Social Security Act and CFR. ▪ These provisions clearly exempt all medically necessary emergency room services from copays. However, there may be additional situations that qualify as emergency services. ▪ For additional information on this provision, see note below. 	
<p>Exempt emergency services (federal definitions): <i>Emergency medical condition</i> means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:</p> <ol style="list-style-type: none"> 1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. 2. Serious impairment to bodily functions. 3. Serious dysfunction of any bodily organ or part. <p>Emergency services means covered inpatient and outpatient services that are as follows:</p> <ol style="list-style-type: none"> 1. Furnished by a provider that is qualified to furnish these services under this title. 2. Needed to evaluate or stabilize an emergency medical condition. 	

The following services are exempt from co-payments:

- Native Americans are always exempt;
- Services rendered by an Indian Health Service, 638 facility or Urban Indian Facility;
- Emergency services deemed medically necessary emergency room visits;
- Family planning services;
- Hospice services;
- Medicare cross-over claims, including claims from Medicare Advantage Plans;
- All services for pregnant members;
- Prenatal and postpartum care and deliveries;
- Prenatal prescriptions;
- Behavioral health and substance abuse services, including psychotropic drug items;
- Preventive services;
- Members exempt due to physical or mental disabilities, or are medically fragile; and
- Family has met maximum out-of-pocket.

Section 6 – Prior Authorization and Utilization Management

The prior authorization (PA) process requires a written request to determine medical necessity/eligibility before the service is rendered. To expedite the review process, pertinent clinical notes (i.e. practitioner office notes, 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.

Practitioners/providers are encouraged to use the Molina Healthcare Web Portal for prior authorization submission. When submitting a request for outpatient services, 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. **Clear Coverage** is for outpatient services.

When using Clear Coverage, practitioners/providers will receive **Auto Approval** if *InterQual 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.

PA Forms and services requiring Prior Authorization based upon regulatory and contractual requirements can be accessed on the Molina Healthcare website at www.molinahealthcare.com

1. Choose New Mexico;
2. For Health Care Professionals;
3. Forms; and
4. “Frequently Used Forms.”

Prior Authorization Requests may be submitted via the following:

- **Molina Healthcare Web Portal** (including **Clear Coverage**):
[Web Portal - Provider Self-Serve](#)

- **Toll Free Fax: (888) 802-5711**

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.) Prior Authorization Request Forms are located on the Molina Healthcare Provider Website at www.molinahealthcare.com

1. Choose New Mexico;
2. For Health Care Professionals;
3. Forms; and
4. “Frequently Used Forms.”

- **Medically Urgent Requests**

In Albuquerque: (505) 798-7371 or Toll free (877) 262-0187

- **Pharmacy**

Toll free fax: (866) 472-4578

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 of New Mexico, Inc. (Molina Healthcare) services that require prior authorization are listed below. Routine/Elective requests must be faxed to Molina Healthcare for all Physical Health requests.

The Prior Authorization/Pre-Service Guide applies to all Molina Healthcare

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

*****Referrals to Network Specialists do not require Prior Authorization*****

**Authorization required for services listed below.
Pre-Service Review is required for elective services.
Only covered services will be paid**

- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:** Refer to Behavioral Health on page 2.
- **Chiropractic Services***
- **Cosmetic, Plastic and Reconstructive Procedures in any setting:** which are not usually covered benefits include but are not limited to tattoo removal, collagen injections, rhinoplasty, otoplasty, scar revision, keloid treatments, and surgical repair of gynecomastia, pectus deformity, mammoplasty, abdominoplasty, venous injections, vein ligation, venous ablation or dermabrasion, botox injections, etc.
- **Dental General Anesthesia:** > 7 years old or per state benefit (Not a Medicare covered benefit)
- **Dialysis:** notification only
- **Diapers (not a Medicare covered benefit), Incontinence products**
- **Durable Medical Equipment/Medical Supplies/Orthotics/Prosthetics:**
Refer to Molina's website for specific codes that require authorization.
Medicare Hearing Supplemental benefit: Contact Avesis at 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: after 3 skilled nursing visits**
- **Home Infusion**
- **Outpatient Hospice & Palliative Care:** notification only.
- **Imaging:** CT, MRI, MRA, PET, SPECT, Cardiac Nuclear Studies, CT Angiograms, intimal media thickness testing, three dimensional (3D) imaging
- **Inpatient Admissions: Acute hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility, Hospice** (Hospice requires notification only)
- **LTC Services (per state benefit):** Refer to Long Term Care Services on page 2. Not a Medicare covered benefit.
- **Neuropsychological and Psychological Testing and Therapy**
- **Non-Par providers/Facilities:** office visits, procedures, labs, diagnostic studies, inpatient stays except for:
 - Emergency Department Services
 - Professional fees associated with ER visits, approved Ambulatory Surgery Center (ASC) or inpatient stay
 - Women's Health, Family Planning and Obstetrical Services
 - Child and Adolescent Health Center Services
 - Local Health Department (LHD) services
 - Other services based on state requirements.
- **Nutritional Supplements & Enteral Formulas**
- **Occupational Therapy** (outpatient and home settings)
 - Under 21 years: After initial evaluation plus 6 visits
 - 21 years and older: After initial evaluation
- **Office-Based Surgical Procedures do not require auth except for Podiatry Surgical Procedures** (excluding routine foot care)
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures:** Refer to Molina's website for specific codes that are **EXCLUDED** from authorization requirements
- **Pain Management Procedures:** including sympathectomies, neurotomies, injections, infusions, blocks, pumps or implants, and acupuncture (Not a Medicare covered benefit)
- **Physical Therapy** (outpatient and home settings)
 - Under 21 years: After initial evaluation plus 6 visits
 - 21 years and older: After initial evaluation
- **Pregnancy and Delivery:** notification only
- **Rehabilitation:** Cardiac Rehabilitation, Pulmonary Rehabilitation, and CORF (Comprehensive Outpatient Rehab Facility) services for Medicare only
- **Sleep Studies**
- **Specialty Pharmacy drugs (oral and injectable) used to treat the following disease states, including but not limited to: Anemia, Crohn's/Ulcerative Colitis, Cystic Fibrosis, Growth Hormone Deficiency, Hemophilia, Hepatitis C, Immune Deficiencies, Multiple Sclerosis, Oncology, Psoriasis, Pulmonary Hypertension, Rheumatoid Arthritis, and RSV prophylaxis** (Refer to Molina's website for specific codes that require authorization)
- **Speech Therapy** (outpatient and home settings)
 - Under 21 years: After initial evaluation plus 6 visits
 - 21 years and older: After initial evaluation
- **Transplant Evaluation and Services:** including solid organ and bone marrow (except Cornea transplants)
- **Transportation:** non-emergent ground and air ambulance
- **Unlisted CPT and 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.
- **Weight Watchers Meetings**
- **Wound Therapy including Wound Vacs and Hyperbaric Wound Therapy**

***Medicare covered service ONLY.**

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

Referrals to Network Specialists do not require Prior Authorization

**Authorization required for services listed below.
Pre-Service Review is required for elective services.
Only covered services will be paid**

Behavioral Health

Members under age 21

- Adaptive Skills Building (Autism)
- Day Treatment Services (Medicare only for PA requirement)*
- Electroconvulsive Therapy (Medicare only for PA requirement)*
- Group Homes
- Infant Mental Health (member ages 0-3: for adult caregivers)
- Inpatient Admissions*
- Intensive Outpatient Program Services (Medicare only for PA requirement)*
- Non-Accredited Residential Treatment Centers
- Office Visits (after 20 during a 12 month period – Medicare only for PA requirements)*
- Partial Hospitalization (Medicare only for PA requirement)*
- Treatment Foster Care
- Treatment Foster Care II

Members age 21 and older

- Day Treatment Services (Medicare only for PA requirements)**
- Electroconvulsive Therapy (Medicare only for PA requirements)*
- Inpatient Admissions*
- Office Visits (after 20 during a 12 month period – Medicare only for PA requirements)*
- Partial Hospitalization (Medicare only for PA requirements)*

*Medicare covered services as well as Medicaid covered services.

**Medicare covered service ONLY.

Long Term Care*

- Enhanced Adaptive Aids (Dual eligible members only)
- Meals on Wheels (Dual eligible members only)
- Nursing Facility (custodial care)
- Reintegration Services (Dual eligible members only)

Agency-Based Community Benefit: the following services can be provided within the member's Individual Service Plan

- Adult Day Health
- Assisted Living
- Behavior Support Consultation
- Community Transition Services
- Emergency Response
- Employment Supports
- Environmental Modifications
- Personal Care Services
- Private Duty Nursing
- Respite
- Skilled Maintenance Therapy Services

Self-Directed Community Benefit: the following services can be provided within the member's Service & Support Plan

- Behavior Support consultation
- Emergency Response
- Employment Supports
- Environmental Modifications
- Home Health Aide
- Homemaker
- Nutritional Counseling
- Private Duty Nursing for Adults
- Related Goods
- Respite
- Skilled Maintenance Therapy Services
- Specialized Therapies
- Transportation (non-medical)

*Medicaid covered service ONLY.

IMPORTANT INFORMATION FOR MOLINA HEALTHCARE/MOLINA MEDICARE

Information generally required to support authorization decision making includes:

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

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

- If a request for services is denied, the requesting provider and the member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the provider by telephone or fax. Verbal and fax denials are given within one business day of making the denial decision, or sooner if required by the member’s condition.
- Providers can request a copy of the criteria used to review requests for medical services.
- Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician at 1 (800) 377-9594.

Important Molina Healthcare/Molina Medicare Information

Monday through Friday 8:00 AM to 5:00 MT

Prior Authorizations:

Medicaid: 1 (877) 262-0187 Fax: 1 (888) 802-5711

Medicare: 1 (888) 825-9266 Fax: 1 (888) 802-5711

Pharmacy Authorizations:

Medicaid: 1 (800) 580-2811 Fax: 1 (866) 472-4578

Medicare: 1 (866) 440-0127 Fax: 1 (866) 450-3914

Behavioral Health Authorizations:

Medicare: 1 (888) 660-7185 Fax: 1 (888) 802-5711

Member Customer Service Benefits/Eligibility:

Medicaid: 1 (800) 580-2811 Fax: 1 (505) 342-0595

Medicare: 1 (866) 440-0127 Fax: 1 (801) 858-0409

TTY/TDD: 1 (800)346-4128

Provider Customer Service: 8:00 am – 5:00 pm (M-F)

Phone: 1 (888) 825-9266 Fax: 1 (505) 342-4711

24 Hour Nurse Advice Line

English: 1 (888) 275-8750 [TTY: 1 (866) 735-2929]

Spanish: 1 (866) 648-3537 [TTY: 1 (866) 833-4703]

Vision Care: March Vision Services

Phone: 1 (888) 493-4070

Hearing Exam Benefits: Medicare (Avesis):

Phone: 1 (800) 327-4462

Dental:

Phone: 1 (800) 580-2811 (Medicaid)

Phone: 1 (855) 214-6779 (Medicare-Avesis)

Transportation (Medicaid/ITM):

Phone: 1 (888) 593-2052

Transportation Medicare (Logisticare):

Phone: 1 (866) 475-5423 (Reservations)

Phone: 1 (866) 474) 5331(Ride Assist)

Providers may utilize Molina Healthcare’s Web Portal at: www.molinahealthcare.com

Available features include:

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

Criteria Used in Making Medically Necessary Decisions – Physical Health

Medically Necessary Services means clinical and rehabilitative physical, mental or behavioral health services that: (i) are 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; (ii) are 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; (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 Member and (v) are not primarily for the convenience of the Member, the provider or Molina Healthcare.

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 Medical Coverage Guidance Documents to determine appropriateness of service requests.

InterQual Smart Sheets are specifically created to guide the provider through the clinical criteria and are available upon request. A copy of other specific guidelines can be requested by contacting the Health Care Services (HCS) Department or your Provider Service Representative.

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. Utilization review criteria, internal guidelines, and nationally recognized criteria are used to determine approval of the requested service authorization.

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.

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.

Behavioral Health Level of Care Guidelines

ACUTE INPATIENT HOSPITALIZATION

I. DEFINITION OF SERVICE:

Acute Inpatient Psychiatric Hospitalization is a twenty-four (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 consumers 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 consumer within 24 hours of admission. The care involves an individualized treatment plan that is reviewed and revised frequently based on the consumer'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.

II. ADMISSION CRITERIA (meets A and B, and C or D, or E or F):

- Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in NMAC 8.305.1, and the consumer has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic intervention;
- Treatment cannot safely be administered in a less restrictive level of care;
- There is an indication of actual or potential imminent danger to self which cannot be controlled outside of a twenty-four (24)-hour treatment setting. Examples of indications include serious suicidal ideation or attempts, severe self-mutilation or other serious self-destructive actions.
- There is an indication of actual or potential imminent danger to others and the impulses to harm others cannot be controlled outside of a twenty-four (24)-hour treatment setting.

An example of an indication includes a current threat and means to kill or injure someone;

- 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 consumer or others in imminent danger. These behaviors cannot be controlled outside of a twenty-four (24)-hour treatment setting; and/or
- 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 consumer, and cannot be managed outside of a twenty-four (24)-hour treatment setting.

III. CONTINUED STAY CRITERIA (meets all):

- The consumer continues to meet admission criteria.;
- An individualized treatment plan that addresses the consumer's specific symptoms and behaviors that required Inpatient treatment has been developed, implemented and updated, with the consumer's and/or guardian's participation whenever possible, which includes consideration of all applicable and appropriate treatment modalities; and
- 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.

IV. DISCHARGE CRITERIA (meets all):

- The consumer has met his/her individualized discharge criteria;
- The consumer can be safely treated at a less intensive level of care; and
- An individualized discharge plan with appropriate, realistic and timely follow-up care is in place.

V. EXCLUSIONARY CRITERIA (may meet any):

- 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; and/or
- The consumer appears to have presented for admission for reasons other than a primary psychiatric emergency, such as homelessness or in appropriate seeking of medications.

Waiting Placement Days (DAP) Rate

I. DESCRIPTION:

Per NMAC 8.311.2.14 (4.MAD 721.5) and NMAC 8312.2 (742.14.A-C) Inpatient Days awaiting Placement (DAP) is a negotiated rate used when a Medicaid eligible consumer no longer meets acute care criteria and it is verified that the eligible consumer requires a residential level of care which may not be immediately located, those days during which the eligible consumer 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.**

II. Approval Criteria (must meet all):

- The consumer is covered by Medicaid as administered by the Medical Assistance Division definition, and the consumer has a DSM diagnosed condition that has required an acute inpatient psychiatric level of care currently;
- The consumer 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;
- 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; and
- 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.

II. Exclusionary Criteria:

- The consumer has met his/her individualized discharge criteria and substantial barriers to discharge no longer exist;
- The inpatient facility cannot demonstrate that it continues to actively work to eliminate barriers to the planned discharge; and
- 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.

23 Hour Observation Stay

I. DEFINITION OF SERVICE:

A twenty-three (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 consumer. The care involves an individual treatment plan that includes access to the full spectrum of psychiatric services. A twenty-three (23) Hour Observation Stay provides an opportunity to evaluate consumers whose needed level of care is not readily apparent. In addition, it may be used to stabilize a consumer in crisis, when it is anticipated that the consumer's symptoms will resolve in less than twenty-four (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 consumer, 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 twenty-four (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:

- The eligible recipient dies;
- 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;
- An eligible recipient is transferred to another facility to obtain necessary medical care unavailable at the transferring facility; or
- 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.

II. ADMISSION CRITERIA (meets A and B, and C OR D, or E):

- Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in NMAC 8.305.1, and the consumer has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic intervention in less than twenty-four (24) hours in a secure setting;
- The consumer cannot be evaluated in a less restrictive level of care;
- The consumer is expressing suicidal ideation or is expressing threats of harm to others that must be evaluated on a continuous basis for severity and lethality;
- The consumer 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; and/or
- The consumer presents with significant disturbances of emotions or thought processes that interfere with his/her judgment or behavior that could seriously endanger the consumer or others if not evaluated and stabilized on an emergency basis.

III. DISCHARGE CRITERIA (meets both):

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

IV. EXCLUSIONARY CRITERIA (may meet any):

- The consumer meets admission criteria for Acute Inpatient Hospitalization; and/or
- The consumer appears to have presented for admission for reasons other than a primary psychiatric emergency, such as homelessness or in appropriate seeking of medications.

ACCREDITED RESIDENTIAL TREATMENT

I. DEFINITION OF SERVICE:

Accredited Residential Treatment Center Services (ARTC) is a service provided to consumers under the age of twenty-one (21) whom, because of the severity or complexity of their behavioral health needs. These are consumers 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 health check or other diagnostic evaluation furnished through a health check referral and the consumer 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 twenty-four (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 consumer'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. Failure to comply with treatment at a detention center does not automatically constitute unsuccessful treatment at a less restrictive level of care.

As discussed in NMAC 8.321.3, 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 shall not implement experimental or investigational procedures, technologies, or non-drug therapies or related services.

II. ADMISSION CRITERIA (meets all):

- Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in NMAC 8.305.1, and the consumer has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic intervention;
- The consumer is experiencing emotional or behavioral problems in the home and/or community to such an extent that the safety or well-being of the consumer or others is substantially at risk. These problems require a supervised, structured, and twenty-four (24)-hour continuous therapeutic milieu. A licensed behavioral health professional has made the assessment that the consumer 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; and
- Less restrictive or intensive levels of treatment have been tried and were unsuccessful, or have proven inadequate to meet the consumer's needs. Documentation exists to support these contentions.

IV. CONTINUED STAY CRITERIA (meets all):

- The consumer continues to meet admission criteria;
- An individualized treatment plan that addresses the consumer's specific symptoms and behaviors that required ARTC treatment has been developed, implemented and updated, with the consumer's or guardian's participation whenever possible, which includes consideration of all applicable and appropriate treatment modalities;
- 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;
- The consumer is participating in treatment, or there are active efforts being made that can reasonably be expected to lead to the consumer's engagement in treatment; and
- The consumer'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.

V. DISCHARGE CRITERIA (meets all):

- The consumer has met his/her individualized discharge criteria;
- The consumer can be safely treated at a less intensive/restrictive level of care; and
- An individualized discharge plan with linkage to appropriate, realistic and timely follow-up care is in place.

VI. EXCLUSIONARY CRITERIA FOR ARTC: (may meet any)

- *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;*
- *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 consumer back into the home is not grounds for continued ARTC care;*
- The individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin;
- Common Criterion # 5 has not been met: *The consumer'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 consumer's motivation have been made, or referrals to community resources or peer supports have been made; and/or*
- Common Criterion # 8 has not been met: *Treatment is not primarily for the purpose of providing respite for the family, increasing the consumer's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.*

RESIDENTIAL TREATMENT CENTER SERVICES

I. DEFINITION OF SERVICE:

Residential Treatment Center Services (RTC), as governed by NMAC 8.321.3 (accredited RTC) and NMAC 8.321.4 (non-accredited RTC) are provided to consumers under the age of twenty-one (21) years who require twenty-four (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 health check screen or other diagnostic evaluation furnished through a health check 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 any financial resource collected or received 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:

- Performance of necessary evaluations and psychological testing for development of the treatment plan, while ensuring that evaluations already performed are not repeated;
- Regularly scheduled structured counseling and therapy sessions for recipients, groups, families, or multifamily groups based on individualized needs, as specified in the treatment plan;
- 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;
- Assistance to recipients in self-administration of medication in compliance with state policies and procedures;
- 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;
- Consultation with other professionals or allied care givers regarding a specific recipient;
- Non-medical transportation services needed to accomplish the treatment objective; and
- Therapeutic services to meet the physical, social, cultural, recreational, health maintenance, and rehabilitation needs of recipients.

NONCOVERED 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:

- Services not considered medically necessary for the condition of the recipients, as determined by MAD or its designee;
- Room and board;
- Services for which prior approval was not obtained;
- Services furnished after the determination is made by MAD or its designee that the recipient no longer needs care
- Formal educational or vocational services related to traditional academic subjects or vocational training;
- Experimental or investigations procedures, technologies, or non-drug therapies and related services;
- Drugs classified as "ineffective" by FDA Drug Evaluations; and
- 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;
- The interdisciplinary team must review the treatment plan at least every thirty (30) days;
- 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:
 - Statement of the nature of the specific problem and the specific needs of the recipient;
 - 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.
- Statement of the least restrictive conditions necessary to achieve the purposes of treatment;

- Description of intermediate and long-range goals, with the projected timetable for their attainment and the duration and scope of therapy services;
- 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;
- 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
- Criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge, and projected date of discharge.

II. ADMISSION CRITERIA (meets all):

- Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in NMAC 8.305.1, and the consumer has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic intervention;
- The consumer 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 consumer or others is at risk. These problems require a supervised, structured, and 24-hour continuous therapeutic milieu in a residential setting;
- A licensed behavioral health professional has made the assessment that the consumer 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; and
- Less restrictive or intensive levels of treatment have been tried and were unsuccessful, or have proven inadequate to meet the consumer's needs. Documentation exists to support these contentions.

III. CONTINUED STAY CRITERIA (meets all):

- *The consumer continues to meet admission criteria;*
- An individualized treatment plan that addresses the consumer's specific symptoms and behaviors that required Residential treatment has been developed, implemented and updated, with the consumer's and/or guardian's participation whenever possible, which includes consideration of all applicable and appropriate treatment modalities;
- 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, or other barriers to discharge exist which the provider has made reasonable efforts to mitigate;
- The consumer is participating in treatment, or there are active efforts being made that can reasonably be expected to lead to the consumer's engagement in treatment; and
- The consumer's parent(s), guardian or/or custodian is participating in treatment and discharge planning, or persistent efforts are being made and documented to involve these individuals unless it is clinically contraindicated.

IV. DISCHARGE CRITERIA (meets A or B, and C, and D):

- The consumer has met his/her individualized discharge criteria;
- The consumer has not realized substantial benefit from Residential Treatment Services despite documented persistent efforts to engage the consumer;
- The consumer can be safely treated at a less intensive/restrictive level of care; and/or
- An individualized discharge plan with linkage to appropriate, realistic and timely follow-up care is in place.

V. EXCLUSIONARY CRITERIA FOR RTC: (may meet any)

- *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;*
- *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 consumer back into the home is not grounds for continued RTC care;*
- The individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin;
- MCO Common Criterion # 5 has not been met: *The consumer'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 consumer's motivation have been made, or referrals to community resources or peer supports have been made; and/or*
- MCO Common Criterion # 8 has not been met; *Treatment is not primarily for the purpose of providing respite for the family, increasing the consumer's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.*

TREATMENT FOSTER CARE I and II

I. DEFINITION OF SERVICE:

Treatment Foster Care (TFC), as governed by NMAC 8.322.2 and NMAC 8.322.5, is a behavioral health service provided to consumers under the age of 21 years who are placed in a twenty-four (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 health check or other diagnostic evaluation furnished through a health check 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 received 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.

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:

- Participation in the development of treatment plans for recipients by providing input based on their observations;
- Assumption of primary responsibility for implementing the in-home treatment strategies specified in a treatment plan;
- Recording information and documentation of activities, as required by the foster care agency and the standards under which it operates;
- Helping recipients maintain contact with their families and enhancement of those relationships;
- Supporting efforts specified by the treatment plan to meet the recipient's permanency planning goals; and

- Assisting recipients obtain medical, educational, vocational, and other services to reach goals identified in treatment plans.

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:

- Assessment of the recipient's progress in TFC and assessment of family interactions and stress;
- Regularly scheduled counseling and therapy sessions for recipients in individual, family, or group sessions;
- 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;
- Crisis intervention, including twenty-four (24) hour availability of appropriate staff to respond to crisis situations; and
- When a return to the natural family is planned, assessment of family strengths and needs and development of a family service plan.

NONCOVERED 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:

- Room and Board;
- Formal educational or vocational services related to traditional academic subjects or vocational training; and
- 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.

- The treatment team must review the treatment plan every thirty (30) days; and
- 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:

- Statement of the nature of the specific problem and the specific needs of the recipient;
- 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.
- Statement of the least restrictive conditions necessary to achieve the purposes of treatment;
- Description of intermediate and long-range goals, with the projected timetable for their attainment and the duration and scope of therapy services;
- Statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including provisions for review and modification of the plan;
- 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
- 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 health check or other diagnostic evaluation furnished through a health check 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, 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 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.

- 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:
 - Participation in the development of treatment plans for recipients by providing input based on their observations;
 - Assumption of primary responsibility for implementing the in-home treatment strategies as specified in an individualized treatment plan;
 - Recording of information and documentation of all activities required by the foster care agency and the standards under which it operates;
 - Helping recipients maintain contact with their families and fostering enhancement of those relationships as appropriate;
 - Supporting efforts specified by the treatment plan to meet the recipient's permanency planning goals; and
 - 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.
- 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:

- Assessment of the recipient and his biological, foster or adoptive family's strengths and needs;
- 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;
- Development and monitoring of the treatment plan;
- Assessment of the recipient's progress in TFC II;
- Assessment of the TFC II family's interaction with the recipient, his or her biological, foster or adoptive family, and any stressors identified;
- 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;
- Ensuring the occurrence of counseling or therapy sessions for recipients in individual, family and/or group sessions as specified in the treatment plan; and
- 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].

NONCOVERED 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:

- Room and Board;
- Formal educational or vocational services related to traditional academic subjects or vocational training; and
- 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.

- The treatment coordinator must review the treatment plan every thirty (30) days;
- 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:
 - Statement of the nature of the specific problem and the specific needs and strengths of the recipient;

- 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.
- Statement of the least restrictive conditions necessary to achieve the purposes of treatment;
- Description of intermediate and long-range goals with the projected timetable for their attainment;
- Statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including provisions for review and modification of the plan;
- 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
- Criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge, and projected date of discharge. [11-1-99]

II. 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.*

- Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in NMAC 8.305.1, and the consumer has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic interventions implemented in a TFC/ family living experience treatment setting.
- The consumer's current (within 30 days of proposed admission) medical and psychiatric symptoms require and can be managed safely in a twenty-four (24)-hour supervised community/home-based setting.
- The consumer 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 consumer's own home or a standard foster care environment.
- A licensed behavioral health professional has made the assessment that the consumer 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.
- There is a recent history (within the past six (6) months) of less restrictive or intensive levels of treatment having been tried and proving unsuccessful, or these services are not currently appropriate to meet the consumer's needs.

FOR TFC I THE FOLLOWING ADDITIONAL ADMISSION CRITERIA MUST BE MET:

- The consumer is unable to participate independently (without twenty-four (24)-hour adult supervision) in age appropriate activities.

FOR TFC II THE FOLLOWING ADDITIONAL ADMISSION CRITERIA MUST BE MET:

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

III. CONTINUED STAY CRITERIA (meets all):

- *The consumer continues to meet all relevant admission criteria;*
- The consumer continues to need twenty-four (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;
- An individualized treatment plan that addresses the consumer's specific symptoms and behaviors that required TFC treatment has been developed, implemented and updated according to licensing rules, with the consumer's and/or legal guardian's participation, which includes consideration of all applicable and appropriate treatment modalities;
- 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;
- The consumer is participating in treatment, or there are active, persistent efforts being made that can reasonably be expected to lead to the consumer's engagement in treatment; and
- 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.

VII. CRITERIA FOR TRANSITION FROM TFC I TO TFC II (meets all):

- A review of the individualized treatment and permanency plan shows that the consumer has met a significant portion of all TFC I treatment goals;
- Continued stay in a treatment foster care setting is necessary to maintain the gains made in TFC I, but consumer does not require the intensity of supervision associated with TFC I; and
- The consumer is able to participate independently in age appropriate activities without continuous adult supervision.

VIII. DISCHARGE CRITERIA (meets A OR B, and C, and D):

- The consumer has met his/her individualized discharge criteria;
- The consumer has not benefited from Treatment Foster Care despite documented persistent efforts to engage the consumer;
- The consumer can be safely treated at a less intensive level of care; and/or
- An individualized discharge plan with appropriate, realistic and timely follow-up care is in place.

IX. EXCLUSIONARY CRITERIA FOR TFC I AND TFC II (may meet any)

- *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;*
- *There is evidence that the TFC treatment episode is intended to defer or prolong a permanency plan determination, or is substituting for permanent housing;*
- The individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin;
- MCO Common Criterion # 5 has not been met: *The consumer'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 consumer's motivation have been made, or referrals to community resources or peer supports have been made; or*
- MCO Common Criterion # 8 has not been met: *Treatment is not primarily for the purpose of providing respite for the family, increasing the consumer's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.*

GROUP HOME

I. 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 consumer's behavioral health needs and the consumer 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 health check screen or other diagnostic evaluation furnished through a health check 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 any financial resource collected or received by provider on 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:

- Performance of necessary evaluations and psychological testing for development of the treatment plan, while ensuring that evaluations already performed are not repeated;
- Regularly scheduled structured counseling and therapy sessions for recipients, groups, families, or multifamily groups based on individualized needs, as specified in the treatment plan;
- 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;
- Assistance to recipients in self-administration of medication in compliance with state policies and procedures;
- 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;
- Consultation with other professionals or allied care givers regarding a specific recipient;
- Non-medical transportation services needed to accomplish the treatment objective; and
- Therapeutic services to meet the physical, social, cultural, recreational, health maintenance, and rehabilitation needs of recipients.

NONCOVERED 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:

- Services not considered medically necessary for the condition of the recipients, as determined by MAD or its designee;
- Room and board;
- Services for which prior approval was not obtained;
- Services furnished after the determination is made by MAD or its designee that the recipient no longer needs care;
- Formal educational or vocational services related to traditional academic subjects or vocational training;
- Experimental or investigations procedures, technologies, or non-drug therapies and related services;
- Drugs classified as "ineffective" by FDA Drug Evaluations; and
- 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.

- The interdisciplinary team must review the treatment plan at least every thirty (30) days.
- 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:
 - Statement of the nature of the specific problem and the specific needs of the recipient;
 - 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.
- Statement of the least restrictive conditions necessary to achieve the purposes of treatment;
- Description of intermediate and long-range goals, with the projected timetable for their attainment and the duration and scope of therapy services;
- 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;
- 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
- Criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge, and projected date of discharge.

II. ADMISSION CRITERIA (meets A, B and C, and either D, or E):

- Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in NMAC 8.305.1, and the consumer has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic intervention;
- The consumer 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;
- Less restrictive or intensive levels of treatment have been tried and were unsuccessful, or are not appropriate to meet the consumer's needs;
- A structured home-based living situation is unavailable or is not appropriate for the consumer's needs; and/or
- The consumer is in need of 24-hour therapeutic milieu, but does not require the intensive staff assistance that is provided in Residential Treatment Center Services.

II. CONTINUED STAY CRITERIA (meets all)

- The consumer continues to meet admission criteria;
- The consumer continues to need twenty-four (24)-hour supervision and assistance to develop or restore skills and behaviors that are necessary to live safely in the home and community;
- An individualized treatment plan that addresses the consumer's specific symptoms and behaviors that required Group Home treatment has been developed, implemented and updated, with the consumer's and/or guardian's participation whenever possible, which includes consideration of all applicable and appropriate treatment modalities;
- 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;
- *The consumer is participating in treatment, or there are active, persistent efforts being made that can reasonably be expected to lead to the consumer's engagement in treatment; and/or*
- 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.

IV. DISCHARGE CRITERIA (meets A or B, and C, and D):

- The consumer has met his/her individualized discharge criteria;
- The consumer has not benefited from Group Home services despite documented persistent efforts to engage the consumer;
- The consumer can be safely treated at a less intensive level of care; and/or
- An individualized discharge plan with appropriate, realistic and timely follow-up care is in place.

V. EXCLUSIONARY CRITERIA (may meet any):

- *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;*
- *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 consumer back into the home is not grounds for continued Group Home care;*
- The individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin;
- MCO Common Criterion # 5 has not been met: *The consumer'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 consumer's motivation have been made, or referrals to community resources or peer supports have been made; or

- MCO Common Criterion # 8 has not been met: *Treatment is not primarily for the purpose of providing respite for the family, increasing the consumer's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.*

ADAPTIVE SKILLS BUILDING (ABS)

I. DEFINITION OF SERVICE

Adaptive Skill Building services (ASB) are provided to children who need intensive intervention to develop skills necessary to function successfully at home and in the community and who require intensive and specialized treatment approaches to learn adaptive behavior. Eligible children include:

- Very young children (recipients birth up to three (3) years of age) with a diagnosis of Autism Disorders (AD), listed in the most current version of the Diagnostic Statistical Manual (DSM) as 299.0;
- Very young children (recipients birth up to three (3) years of age) with a diagnosis of Pervasive Development Disorder/not otherwise specified (PDD/NOS), listed in the most current version of the DSM as 299.8.;
- Young children (recipients three (3) up to five (5) years of age) with a diagnosis of Autism Disorders (AD), listed in the most current version of the Diagnostic Statistical Manual (DSM) as 299.0; and
- The evaluation leading to the diagnosis should be thorough and include information from multiple sources, because the child's performance may vary among settings and caregivers.

ASB services include the development of an Intervention Plan, implementation of the plan, application of Applied Behavior Analysis, assistance for caregivers in socially purposeful engagement of the recipient, and ongoing monitoring of the plan and recipient progress being made. This service includes the use of basic Applied Behavior Analysis techniques provided as part of a comprehensive approach to the treatment of Autism Disorders. The treatment plan should include caregiver training regarding identification of the specific behavior(s) and interventions, in order to support utilization of the ABA techniques by caregiver(s).

The initial ASB authorization will be for six (6) months; ongoing ASB interventions shall be authorized for three months.

II. ADMISSION CRITERIA (Must meet all.)

- Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in NMAC 8.305.1, and the consumer has a

DSM diagnosed condition that requires, and is likely to benefit from, therapeutic intervention;

- There is documentation of a DSM-IV-TR diagnosis by a clinical psychologist or psychiatrist with experience treating Autism of a diagnosis of Autism Disorders (AD) for recipients aged birth up to five (5) years of age;
- There is documentation of maladaptive behaviors that would require adaptive skill building services;
- **Each qualifying child must need intensive intervention to develop skills necessary to function successfully at home and in the community and also must require intensive and specialized treatment approaches to learn adaptive behaviors;**
- There is a reasonable expectation on the part of a treating health care professional that the individual's behavior will improve with adaptive skill building services; and
- A comprehensive evaluation has been done which includes the following components:
 - Health, developmental, and behavioral histories that include a family history and a review of systems;
 - Other diagnoses have been considered and an appropriate evaluation has been done to rule out those diagnoses;
 - Confirmation of the presence of a categorical DSMIV-TR diagnosis meeting the criteria for this service using specific evidence to support the diagnosis including standardized tools that operationalize the DSM criteria; and
 - The parents'/guardians' knowledge of ASD, coping skills, and available resources and supports have been assessed and there is evidence that the parents/guardians can participate in Adaptive Skill Building.

III. CONTINUED STAY CRITERIA (Must meet A through C, or both A and D.):

- The consumer continues to meet the admission criteria;
- There is evidence the child, family, and social supports can continue to participate effectively in this service;
- There is evidence the consumer is responding positively to the service; and/or
- If the consumer is not responding positively to the service or if the child, family, or social supports are not adequately participating in the service the treatment plan must reflect what interventions will change to produce effective results.

IV. DISCHARGE CRITERIA (Meets A, or B, or C, or D, and E.):

- The child has met his/her individualized discharge criteria;
- The child can be appropriately treated at a less intensive level of care;
- The child has reached his or her fifth (5th) birthday;
- The child has received thirty-six (36) months (cumulative) of Adaptive Skill Building services; and
- An individualized discharge plan with appropriate, realistic and timely follow-up care is in place.

V. EXCLUSIONARY CRITERIA (may meet any):

- The child is not responding to ASB services in a way that suggests the services are effective and meets admission criteria for a higher, more intensive, or more restrictive, level of care; or
- The child's parent(s) or legal guardian is not substantially involved in the child's treatment and/or the services are being used in place of respite (see common criterion #8).

INITIAL INPATIENT ADMISSION REVIEW

Molina Healthcare contracts require prior authorization **before** a hospital admission for many elective procedures and for scheduled, non-emergent hospitalizations. 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. The purpose of this review is to assure that:

- Only patients with a medical need for hospitalization are approved for admission;
- The proposed treatment is customary for the diagnosis; and
- Treatment will take place in the most cost effective and appropriate setting.

ADMISSION REVIEW PROCESS

Elective, non-urgent hospitalizations:

- Prior authorization is required for elective, non-urgent admissions, including admissions for elective procedures;
- For elective hospitalizations and procedures requiring overnight hospital stay, the facility needs to fax notification toll free to **(866) 472-4575** on the date of admission; and
- 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 **(866) 472-4575** within three (3) business days – see “Concurrent Inpatient Admission Review” process below.

Urgent/Emergent Hospitalizations

- In the event that the hospitalization is of an emergent/urgent nature, the facility/practitioner must fax admission notification within one (1) working day of admission toll free to **(866) 472-4575**;
- All weekend and/or holiday inpatient or hospital observation admissions are subject to retrospective review for medical necessity;
- For admissions over the weekend/holiday, facility reviews are expected to contain appropriate clinical evidence of services administered over the weekend/holiday;
- Concurrent utilization review is required for all contracted facilities. Review documentation is to be faxed toll free to **(866) 472-4575** within three (3) business days, refer to “Concurrent Inpatient Admission Review” process below;
- The Medical Director, may call the attending practitioner for more information if questions arise relating to the admission;
- When coverage is denied based on lack of medical necessity, Molina Healthcare will notify the facility/practitioner and send letters to the Member, the requesting facility and the Primary Care Practitioner (PCP);
- All medical necessity denials are made by a Molina Medical Director;
- 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
- 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

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

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 payor source for the Nursing Facility stay;
- Change in a Member’s known circumstances; and
- Member’s pending discharge (must be in writing).

The Nursing Facility Level of Care Notification Form and Communication Form are located on the Molina Healthcare Website at www.molinahealthcare.com

1. Choose New Mexico;
2. For Health Care Professionals;

3. Forms; and
4. Frequently Used Forms.

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 three (3) business days after (1) admission or (2) re-review date as specified by Molina Healthcare HCS review staff. Failure to submit such documentation within the specified 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.

On Site Review

Some facilities may receive on-site review by Molina Healthcare nursing staff. When Molina 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.

Non-Contracted Facilities (Elective and Urgent/Emergent Hospitalizations)

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.

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 Human 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 policies for provider preventable conditions (PPCs) including health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs).

– 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:

- Foreign Object Retained After Surgery;
- Air Embolism;
- Blood Incompatibility;
- Stage III and IV Pressure Ulcers;
- Falls and Trauma; including Fractures, Dislocations, Intracranial Injuries , Crushing Injuries, Burns, Electric Shock;
- Catheter-Associated Urinary Tract Infection (UTI);
- Vascular Catheter-Associated Infection;
- Manifestations of Poor Glycemic Control; including: Diabetic Ketoacidosis, Nonketotic Hyperosmolar Coma, Hypoglycemic Coma, Secondary Diabetes with Ketoacidosis, Secondary Diabetes with Hyperosmolarity; and
- 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.

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 shall 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.

Other Provider Preventable Conditions: 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):

CONDITION 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](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Provider-Preventable-Conditions.html)

Thirty (30) Day Hospital Readmissions:

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.

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 business 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 decision
Urgent concurrent review (i.e. inpatient, ongoing ambulatory services)	Within 1 business day of receipt of request	Within 1 business day of decision
Routine Concurrent	Within 10 business days of receipt of request	Within 1 business day of decision
Post-service decisions	Within 30 calendar days of receipt	
Residential Services (RTC, TFC, Group Homes)	Within 5 business days of receipt of request	Within 1 business day of decision

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 (2nd) 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 doctor for a referral to see another practitioner or specialist to obtain a second opinion; 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 (2nd) opinion.

If a Member requires a second (2nd) 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 (3rd) opinion.

Communication Services

Practitioners/providers seeking information about the utilizations management (UM) process or UM decisions may contact our Health Care Services (HCS) 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 a practitioner would like to discuss a case, our staff can put you in telephone contact with one of Molina Healthcare's Medical staff.

Ensuring Appropriate Service and Coverage

Molina Healthcare reminds our practitioners/providers that:

- 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.

Section 7 – Care Management / Care Coordination

Molina Healthcare recognizes the emotional impact the diagnosis of a serious or catastrophic illness can have on a patient. Molina Healthcare has a Care Management program that can help you better manage your patient's 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 Member'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 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
Toll free fax: (866) 472-4575

Toll free telephone: (800) 377-9594, ext. 181120

Care Coordination/ Care Management Referral Forms can be accessed via the Molina Healthcare Provider Portal at: [Care Coordination Form](#)

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 1-3;
- Comprehensive needs assessments (including level of care);
- Determines the Member's physical and behavioral health, and long-term care needs;
- Develops and updates of an Individual Service Plan (ISP)/Care Plan based upon the Member's individual needs and preferences; and
- On-going coordination services based upon Members 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 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 or the Member's PCP if they detect a change in the Member's condition.

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.

Care Coordination for Individuals with Special Health Care Needs (ISHCN)

Molina Healthcare recognizes the special needs of ISHCN's and provides care management and service coordination to these Members on an as-needed basis. Care Management can help to ensure the medical and behavioral health needs of the Member are met and coordinated with appropriate associated services such as Children, Youth and Families Department (CYFD) and School-Based Programs, etc. Molina Healthcare promotes a high level of Member compliance with follow-up appointments, consultations/referrals, and diagnostic laboratory, diagnostic imaging and other testing.

If you have questions regarding this program, or would like to refer a Molina Healthcare Member to this service, please call in **Albuquerque (505) 342-4660, extension 181120 or toll free (800) 377-9594, extension 181120. Care Coordination/ Care Management Referral Forms can be accessed via the Molina Healthcare Provider Portal at: www.molinahealthcare.com**

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? Are 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 8 – 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 information about the condition and provide him/her with assistance from our staff to help him/her manage his/her condition. The programs are designed to reinforce your treatment plan for the patient. We also provide pregnant Members who are at risk for complications with a pregnancy program.

Members of Molina Healthcare are automatically enrolled when we identify him/her with the disease. However, if you would like to enroll a Molina Healthcare patient who is not already in the program, please let us know. We will inform you of his/her participation, and we will provide you with updates on the results of tests or other information that Molina Healthcare collects on your patient. Membership in these health management programs is voluntary. If at any time your patient wishes to stop participating in the program, he/she can call Molina Healthcare and inform us of his/her decision. Our health management referral form is located on our website at www.molinahealthcare.com.

breathe with easesm

Molina Healthcare provides a health management program called ***breathe with easesm***, designed to assist Members in understanding their condition. Molina Healthcare has a special interest in asthma, as it is the number one chronic disease diagnosis for our Members. This program was developed with the help of several community providers with large asthma populations. The program educates the Member and family about asthma symptom identification and control. Our goal is to partner with you to strengthen asthma care in the community. The complete ***breathe with easesm*** program description that includes how to use health management services and how Molina Healthcare works with a practitioner's patients in the program is located on our website at www.molinahealthcare.com.

Each identified Member will receive specific educational materials and other resources in accordance with their assigned stratification level. Additionally, all identified Members will receive periodic educational newsletters.

Healthy Living with COPDsm

Molina Healthcare has a health management program called ***Healthy Living with COPDsm***. Molina Healthcare's ***Healthy Living with COPDsm*** health management program is a collaborative team approach comprised of patient education, clinical care management and provider education. The team works closely with contracted practitioners in the identification, assessment and implementation of appropriate interventions for Members with COPD. Molina Healthcare's goal is to promote to the Member routine follow-ups with their Primary Care Practitioner and/or specialist to ensure the receipt of optimal medical care. This program is designed for adults who are active Molina Healthcare Members thirty-five (35) years of age or older upon enrollment in the program. The Member must have a confirmed diagnosis of COPD. The Member participates in the program for the duration of his or her eligibility or until the Member "opts out". Each identified Member will receive specific educational materials and other resources in accordance with their assigned stratification level. Additionally, all identified Members will receive periodic educational newsletters. The complete ***Healthy Living with COPDsm*** program description that includes how to use health management services and how Molina Healthcare works with a practitioner's patients in the program is located on our website at www.molinahealthcare.com

Healthy Living with Diabetessm

Molina Healthcare has a health management program called ***Healthy Living with Diabetessm*** designed to assist Members in understanding diabetes and self-care. The ***Healthy Living with Diabetessm*** program is designed for Members eighteen (18) years of age or older upon enrollment in the program. The Member must have a confirmed diagnosis of diabetes, (non-gestational and/or non-steroid-induced). The Member will participate in the program for the duration of his or her eligibility with the plan's coverage or until Member opts out. Each identified Member will receive specific educational materials and other resources in accordance with their assigned stratification level. Additionally, all identified Members will receive periodic educational newsletters. The complete ***Healthy Living with Diabetessm*** program description that includes how to use health management services and how Molina Healthcare works with a practitioner's patients in the program is located on our website at www.molinahealthcare.com.

Heart Healthy Livingsm

Molina Healthcare has a health management program called ***Heart Healthy Livingsm*** 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. The complete ***Heart Healthy Livingsm*** program description that includes how to use

health management services and how Molina Healthcare works with a practitioner's patients in the program is located on our website at www.molinahealthcare.com

***motherhood matterssm* Pregnancy Program**

Molina Healthcare also offers a voluntary educational program for pregnant Members called the ***motherhood matterssm* 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 matterssm*** Pregnancy Program. Your patients will be given additional education, guidance and resources.

Members enrolled in the ***motherhood matterssm*** Pregnancy Program receive a free infant car seat for completing the prenatal education and car seat safety program. They also receive a free convertible 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

Manage Your Chronic Disease (MyCD) Program

Molina Healthcare of New Mexico, Inc. (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 for a workshop call Molina Healthcare’s Health Improvement Hotline toll free at (800) 377-9594, extension 182618 or (505) 342-4660, extension 182618 in Albuquerque.

Section 9 – Pharmacy and Formulary Services

Preferred Drug List

The development and maintenance of the Molina Healthcare formulary, or Preferred Drug List (PDL) is overseen by the Pharmacy and Therapeutics (P&T) Committee, whose mission is to ensure access to the medications and treatments that meet or exceed established standards for the delivery of quality care. This committee meets every other month and is comprised of health care professionals 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 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: <http://www.molinahealthcare.com/medicaid/providers/nm/drug/Pages/formulary.aspx>.

In addition, a list of drugs requiring prior authorization and step-therapy and prior authorization criteria is also contained on this link. Paper copies of the Molina Healthcare PDL may also be obtained by calling the Member Service Department in **Albuquerque at (505) 341-7493**.

The Medication Prior Authorization Request Form and Suboxone Induction Notification may be downloaded for fax via this link. [Medication Prior Authorization Request Form](#)
[Suboxone or Subutex Prior Notification Form](#)

The Suboxone form should be completed prior to the visit with the Member.

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 (greater than \$200), complete a copy of the Molina Healthcare Medication Prior Authorization Request Form (located at the end of this section and on the Molina website as a Quick Link under “New Mexico” and “Provider”) and fax it to Molina Healthcare Pharmacy Prior Authorization Department in **Albuquerque at our 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.

Non-Formulary Requests for Oral Medications

Complete the Medication Prior Authorization Request Form: [Medication Prior Authorization Request Form](#) and fax it to the Molina Healthcare Pharmacy Prior Authorization Department in **Albuquerque at our 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.

Formulary Addition Requests From Practitioners

We value and want your feedback. Molina Healthcare convenes a Pharmacy & Therapeutics (P&T) Committee to review formulary changes. The committee is composed of community practitioners from various backgrounds and expertise.

To request a Formulary Addition, download the Formulary Addition Request Form: [Formulary Addition Request Form](#) Please fax this form to Molina Healthcare in **Albuquerque at our toll free number (866) 472-4578**. The P&T Committee will review the request as soon as possible and communicate its decision to the requesting practitioner.

Medicare Part D Benefit

Dual Eligible Molina Healthcare Members (Members with both Medicare and Medicaid) will receive their primary drug coverage through Medicare Part D. Molina Healthcare will provide wrap-around prescription drug coverage for selected members that are on medication in drug classes not covered through Medicare Part D. 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.

Pharmacy and Therapeutics (P&T) Committee Membership

If you are interested in becoming a member of the Molina Healthcare P&T Committee, please communicate this via faxed memo to the P&T Chairperson in **Albuquerque at our toll free number (866) 472-4578.**

Section 10 – Provider Credentialing / Recredentialing

Molina Healthcare will adhere to the State’s policies to conduct background checks and similar activities as required under the Patient Protection Affordable Care Act (PPACA) on all practitioners/providers before entering into any agreement. Molina Healthcare credentials practitioners/providers in accordance with internal policies and procedures. These policies and procedures meet standards and guidelines set forth by state, federal, and national accrediting bodies, including the National Committee for Quality Assurance (NCQA), the New Mexico Department of Insurance (DOI), and the New Mexico Human Services Department (HSD).

Molina Healthcare requires all licensed practitioners/providers who fall within the defined scope of Credentialing Policies and Procedures to meet and maintain standards and requirements established by Molina Healthcare. Defined practitioners/providers are required to be credentialed by Molina Healthcare prior to seeing a Molina Healthcare Member. Molina Healthcare Incorporated, (MHI) performs Molina Healthcare's primary source verification of practitioner information.

Practitioners/providers formally credentialed for Molina Healthcare by a delegated entity will be required to go through the initial credentialing process with Molina Healthcare to ensure our standards are maintained.

Practitioners/providers will be listed in directories and other Member materials consistent with verified credentialing data to include name, gender, specialty, hospital affiliations, medical group affiliations (if applicable), board certification, acceptance of new patients, and office locations.

- Medical Doctors (M.D). and Doctors of Osteopath (D.O.) board certification is mandatory during the credentialing process for urban area practitioners based on network need as determined by the Provider Interest Committee; and
- Maintaining board certification is a recredentialing requirement for urban areas based on network need.

Only the American Board of Medical Specialties, the American Osteopathic Association, or their affiliate boards will be recognized for M.D.s or D.O.s.

Interested Practitioners/Providers

The Molina Healthcare Provider Web Portal contains the following forms for practitioners/providers interested in joining the Molina Health Care Provider Network can be accessed on the Molina Healthcare Website at www.molinahealthcare.com

1. Choose New Mexico;
2. For Health Care Professionals;

3. Forms; and
4. Frequently Used Forms.

Practitioner Rights

As a Molina Healthcare network practitioners/providers, you have the right to:

- Review information submitted to support your credentialing application;
- Correct erroneous information collected during the credentialing process;
- Be informed of the status of your credentialing or recredentialing application; and
- Be notified of these rights.

Individual Professional Service Providers

Initial Credentialing

At the time of initial credentialing, the applicant must complete a Practitioner Information Form (PIF), Ownership and Control Disclosure Form and a uniform New Mexico Statewide Application or Council for Affordable Quality Healthcare (CAQH) Application. CAQH use is the preferred application method and will ensure the most efficient submission and process. The uniform credentialing forms may be used in electronic or paper format, as determined by Molina Healthcare. Molina Healthcare will not require an applicant to submit information other than what is required by these credentialing forms. An exception is made for health professionals who: (a) are subject to credentialing under Molina Healthcare's internal policy; (b) practice outside of New Mexico;* and (c) prefer to use the credentialing forms required by their respective states. In such circumstances, Molina Healthcare and its delegated entity, if any, may accept those forms and any applicable attachments to the application.

** Telehealth practitioners/providers residing out of state are subject to their resident state's licensing requirements and must hold an active New Mexico telemedicine license.*

The credentialing process will be completed within forty-five (45) days from receipt of 'completed' application with all required documentation unless there are extenuating circumstances. The application must include a signed attestation (a signature stamp is not acceptable on the attestation). If the information that is attested to conflicts with itself or is shown to be incorrect through primary source verification, then the application will be deemed 'incomplete' until these items are resolved. The attestation must include:

- Reason for any inability to perform the essential functions of the position, with or without accommodation;
- Lack of present illegal drug use;
- History of loss of license and felony convictions; and/or
- History of loss or limitation of privileges or disciplinary action;

Current malpractice insurance coverage - Molina Healthcare minimum malpractice insurance requirements are: \$200,000/\$600,000 for New Mexico practitioners and \$100,000/\$300,000 for Texas based practitioners; \$1,000,000/\$3,000,000 for all organizations, or coverage provided by a federal program.

For behavioral health practitioners/providers a minimum of \$1 million occurrence/\$1 million aggregate for master's-level and doctoral-level providers, and a minimum of \$1 million/\$3 million for physicians (exceptions to these required insurance amounts may be made as required by applicable state law).

- Malpractice coverage for practitioners/providers contracted with Molina Healthcare practicing in other states is required to mirror malpractice standards for that state; and
- Medicare or Medicaid sanctions; and/or
- The correctness and completeness of the application.

The correctness and completeness of the application will consist of:

- Practitioner's information;
- Full Name (other names & suffix if applicable);
- Social Security Number (SSN);
- Date of Birth (DOB);
- Tax Identification Number (TIN);
- National Provider Identifier (NPI);
- Practice/Group Name;
- Effective Date;
- Complete Physical Address;
- Telephone and& Fax numbers;
- Current Mailing and Billing Address;
- Home Address;
- Education;
- Post Graduate Training (if applicable).
- Work History (last five (5) years – must include Month & Year);
- Specialty Board Certification (if applicable);
- Licensure/Registration/Certification Information;
- Licenses;
- Drug Enforcement Administration (DEA) or, Controlled Substance Registration (CRS) Certificate;
- Professional Liability Insurance;
- Hospital and Healthcare affiliations (if applicable);
- Professional Practice Questions (PPQs);
- Release/Attestation Currently Signed & Dated (within the last one hundred twenty (120) days of receipt);
- Admitting Arrangement Letter (if applicable);
- Educational Commission for Foreign Medical Graduates (ECFMG) (if applicable); and
- Curriculum Vitae (CV) or Resume (must include months & years for the last five (5) years.

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 by the Medical Director for files with issues and/or the Molina Healthcare's Professional Review Committee Molina Healthcare's Professional Review Committee (PRC).

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 forty-fifth (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. This notification will be sent through standard mail, fax, or electronic mail 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 and once this timeframe is exhausted the file will be closed.

Requests for Additional Information

Within ten (10) working days after receipt of an incomplete application, Molina Healthcare will notify the practitioner/provider in writing of all missing or incomplete information or supporting documents. The notice will include:

- A complete and detailed description of all of the missing or incomplete information or documents that must be submitted in order for review of the application to continue;
- Within forty-five (45) calendar days after receipt of all of the missing or incomplete information or documents, Molina Healthcare will assess and verify the practitioners/providers qualifications and notify the practitioner of its decision;
- If the missing information or documents have not been received within forty-five (45) calendar days after initial receipt of the application or if date-sensitive information has expired, Molina Healthcare will close the application or delay final review, pending receipt of the necessary information;
- The practitioner/provider will be informed of the closed or pending status of the application and, where applicable, the length of time the application will be pending; and
- The name, address and telephone number of a credentialing staff person who will serve as the contact person for the practitioner/provider.

If the signature attestation will be older than one hundred eighty (180) calendar days at the time of the credentialing decision, the practitioner/provider will be required to update the attestation. Molina Healthcare will send a copy of the completed application with a new attestation form when requesting that the practitioner/provider update the attestation.

Provider Right to Correct Information

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

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

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

- The requirement to submit a written response within ten (10) calendar days of receiving notification from Molina Healthcare;
- In the response, the practitioner/provider must explain the discrepancy, may correct any erroneous information and may provide any proof that may be available; and
- The response must be sent to Molina Healthcare of New Mexico, Inc.: Attention Credentialing Director at PO Box 2470 Spokane WA 99210

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

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

Practitioner/Provider Right to Appeal

Practitioners/providers who have applied for initial participation and have been denied by the PRC do not have the right to file an appeal to request reconsideration of the decision.

Practitioner/Provider Right to Request Status of Application

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

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

Practitioner/Provider Right to Review Credentials File

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

The practitioner/provider must notify the Credentialing Department and request an appointed time to review their file and allow up to seven (7) calendar days to coordinate schedules. A Medical Director, Director of Quality Improvement and Credentialing Specialist will be present. The practitioner/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 are documents, which the practitioner/provider sent to Molina (e.g., the application, the license and the DEA certificate). Practitioners/providers may not copy documents that include pieces of information that are confidential in nature, such as the practitioner/provider credentialing checklist, the responses from monitoring organizations (i.e. National Practitioner Data Bank, State Department of Health, Health Professional Quality Assurance), and verification of hospital privileges letters.

Confidentiality

Molina Healthcare will maintain the confidentiality of all information obtained regarding practitioner/provider in the credentialing and recredentialing process as required by law.

Molina Healthcare will not disclose confidential practitioner/provider credentialing and recredentialing information to any person or entity except with the written permission of the provider or as otherwise permitted or required by law.

Non-Discrimination

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) with which the practitioner/provider specializes. This does not preclude Molina Healthcare from including in its network practitioners/providers who meet certain demographic or specialty needs; for example, to meet cultural needs of Members. Molina Healthcare takes appropriate steps to protect against discrimination occurring in the credentialing and recredentialing processes. Molina Healthcare maintains a heterogeneous credentialing committee Membership and requires the committee Members to sign an affirmative statement at every meeting to make decisions in a nondiscriminatory manner.

Notification of Credentialing Decisions

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

Office Site Visits

Molina Healthcare will conduct a site visit of the offices of all Primary Care Practitioners (PCPs), Obstetrics/Gynecological (OB/GYN) practitioners and all potential high volume behavioral health facilities for initial credentialing, unless an approved accreditation certification is provided in accordance with internal policies and procedures.

All site visits must meet the threshold requirement for Molina Healthcare, including complying with the American Disabilities Act (ADA), which guarantees equal opportunity for individuals in public and private sectors service and employment. The practitioner/provider of medical care contracted with Molina Healthcare will not discriminate against Members with regard to the eligibility to enroll based upon health status or any physical or mental disability.

Members will receive and access medical care in a non-discriminatory fashion regardless of diagnosis or physical or mental limitations. Public Law 101-336, Section 36.304 requires public accommodations remove architectural barriers in existing facilities, i.e., easily accomplishable and able to be carried out without much difficulty or expense. It is the responsibility of the building owner and/or property owner and the occupying tenant to comply with state and federal regulation

Practitioner/Provider offices/facilities must meet the following ADA criteria:

- Designated Parking must be available and at least one per facility;
- Curb ramp must:
 - Be a minimum width of forty-eight (48) inches wide; and
 - Have space for parked vehicles must not obstruct use of ramp;

- Main entrance ramp must be a minimum width of forty-eight (48) inches wide;
- Elevator must be a minimum width of forty-eight (48) inches wide;
- Water fountain must be accessible with a paper cup dispenser or the office must have staff available to assist the Member in obtaining water.
- Restroom must:
 - Be handicap accessible or alternative access;
 - Have staff available to assist Member in accessing an inaccessible restroom; and
 - Have handrails installed.
- If the threshold score is not met at the time of the visit, a corrective action plan will be initiated, and a re-audit will be conducted within sixty (60) days of the visit;
- If the re-audit does not produce a passing score, the practitioner will be presented to the Professional Review Committee with a recommendation from Credentialing to terminate; or
- A provider who relocates or opens an additional office site after being initially credentialed must notify Molina Healthcare thirty (30) days prior to the move.

Molina Healthcare will conduct a new site visit when:

- A practitioner leaves a group practice to open a new office;
- A practitioner moves from one location to another and there has been no previous office site visit at the new location; or
- A practitioner opens an additional office and there has been no previous office site visit at the new location.

A Member grievance related to an office environment issue will be cause for an additional site visit, which will be conducted at any time between credentialing cycles.

Recredentialing

Molina Healthcare credentials its practitioner/provider at least every thirty-six (36) months. Approximately six (6) months prior to the recredentialing due date, a request will be sent to the practitioner/provider requesting completion of a recredentialing application. The applicant must complete a uniform New Mexico Statewide Application or Council for Affordable Quality Healthcare (CAQH) Application and the Ownership and Disclosure form. The uniform recredentialing forms may be used in electronic or paper format, as determined by Molina Healthcare. Molina Healthcare will not require practitioner/provider to submit information other than what is required by the uniform recredentialing forms. An exception is made for health professionals who: (a) are subject to recredentialing under Molina HealthCare's internal policy; (b) practice outside of New Mexico; and (c) prefer to use the recredentialing forms required by their respective states. In such circumstances, Molina Healthcare and its delegated entity, if any, may accept those forms and any applicable attachments to the application.

Practitioners/providers are instructed to update the information and make corrections as necessary, answer all PPQs and sign and date the attestation and release of information statements. A signature stamp is not acceptable on the attestation.

If a practitioner/provider fails to return the completed recredentialing packet to Molina Healthcare within seven (7) weeks, it will result in an administrative termination from the Molina Healthcare network.

Molina Healthcare follows the same timeframe for processing recredentialing files as for initial files as previously described.

Board Certification during Recredentialing

As of July 1, 2004, M.D.s and D.O.s must maintain Board Certification to meet recredentialing requirements based on network need as determined by the Network Management and Operations Department.

Only American Board of Medical Specialties, American Osteopathic Association, or their affiliate boards will be recognized for M.D.s or D.O.s.

On-Going Performance Monitoring

It is the standard of Molina Healthcare to provide ongoing quality monitoring for all practitioner/provider to ensure the highest quality of care for our Members. Monitoring of quality and/or office environment issues occur within Molina Healthcare on a continual basis.

All practitioners/providers will be required to have performance monitoring considered by the PRC at the time of credentialing or recredentialing. Practitioner/provider specific information that is taken into consideration includes:

- Quality activities;
- Member complaints;
- Utilization patterns;
- Quality of Care (QOC) issues;
- Anti-Fraud issues;
- Pharmacy and therapeutics patterns; and
- Member satisfaction survey results (optional).

The Data Bank Continuous Query Service

All Molina Healthcare network practitioners/providers will be enrolled in this service. Once the practitioner/provider is enrolled in the Continuous Query Program, Molina Healthcare will receive instant notification of all new National Practitioner Data Bank (NPDB)/Healthcare Integrity and Protection Data Bank (HIPDB) reports against the enrolled practitioner/provider. When a new report is received, the Molina Ongoing Monitoring Credentialing Specialist will review the new NPDB/HIPDB report. If the new report is a malpractice case, the report will be filed in the practitioner/provider's permanent credentialing file to be reviewed during the normal

recrediting process. If the new NPDB/HIPDB report is an Adverse Action report, the practitioner will be immediately placed into the full credentialing process and will be recrediting early. The practitioner/provider must provide all necessary information to complete the recrediting process within the requested time-frames or the practitioner will be administratively terminated from the network. The complete recrediting file will be reviewed at the next scheduled Credentialing Committee meeting for a determination.

Organizational Provider Credentialing – Health Delivery Organizations (HDO)

Molina Healthcare credentials HDOs in accordance with internal policies and procedures. These policies and procedures meet standards and guidelines set forth by State, Federal, National and Accrediting bodies, including National Committee for Quality Assurance (NCQA), Department of Insurance (DOI), and Human Services Department (HSD). Molina Healthcare requires all HDOs who fall within the defined scope of credentialing to meet and maintain standards and requirements established by Molina Healthcare.

Molina Healthcare credentials all organizational providers that are licensed, certified and/or regulated by the state as a facility or organizational provider. The organizational provider types credentialed include but are not limited to the following:

Quality assessments are conducted on the following types of HDOs:

- Hospitals;
- Home health care agencies;
- Skilled nursing facilities/nursing homes;
- Free-standing surgical centers;
- Behavioral Health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting;
- Long-term care;
- Adult day care;
- Residential treatment centers;
- Intermediate care facilities for the mentally retarded (ICF/MR) and other entities that provider long-term care services as specified by the State.

Before contracting, Molina Healthcare verifies the HDO has met the following criteria for network participation. The detailed criterion is listed in the attached Criteria and Primary Source Verification Table.

- Meets all state and federal and licensing requirements;
- Is in good standing with state and federal regulatory agencies;
- Lack of sanctions prohibiting participation in Medicaid/Medicare;
- Professional liability coverage limit of at least \$1,000,000/\$3,000,000 which covers the facility and all providers practicing at the facility;

- Reviewed, approved and in good standing by one of the accrediting agencies approved by Molina Healthcare or a passing site survey by an accrediting agency, state or federal government agency, or by Molina Healthcare;
- Molina Healthcare confirms that the HDO has been reviewed and approved by an acceptable accrediting body or an appropriate on site quality assessment has been performed and has met minimal threshold standards. Non-accredited HDOs must provide a copy of the most recent Centers for Medicare and Medicaid Services (CMS) or approved survey agency results, including HDOs corrective action plans (CAPs) to any survey deficiencies; and, a copy of the letter verifying acceptance of the CAP by the survey agency. Molina Healthcare verifies that the review was done and meets Molina Healthcare standards.

Molina Healthcare requires the following documentation from HDOs:

- Facility Information Form (FIF)
- Ownership & Disclosure form
- Completed Molina Healthcare Health Delivery Organization Application;
- Copy of state license (if applicable);
- Copy of the most recent accreditation survey or the most recent Medicare site survey including HDO's corrective action plan to any deficiencies and a copy of the letter verifying acceptance of the CAP by the survey agency;
- Professional liability insurance declaration page showing dates and amount of coverage; and
- Copy of current DEA certificate (if applicable).

Approved accrediting agencies accepted by Molina Healthcare are the following:

- The Joint Commission (JC);
- 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);
- Community Health Accreditation Program (CHAP);
- The Accreditation Commission for Health Care, Inc. (ACHC);
- The Council on Accreditation (COA).
- DNV Healthcare (DNVHC);
- The Commission for the Accreditation of Birth Centers (CABC);
- American Society of Histocompatibility and Immunogenetics (ASHI);
- College of American Pathologists (CAP);
- Commission on Laboratory Accreditation (COLA); and
- American Association of Blood Banks (AABB).

After the initial assessment, Molina Healthcare confirms at least every thirty-six (36) months that the HDO continues to be in good standing with state and federal regulatory bodies and if applicable, reviewed and approved by an accrediting body.

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 by the Medical Director for files with issues and/or the PRC.

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 forty-fifth (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 and once this timeframe is exhausted the file will be closed.

Provider Internal Fair Hearing - Terminations Based on Cause

The fair hearing process is available to practitioners/providers when disputing whether Molina Healthcare has adequate cause to terminate his/her participation with Molina Healthcare. The practitioner/provider is notified in writing thirty (30) calendar days prior to the proposed termination except when the quality of care provided to patients is the basis of Molina Healthcare's proposed termination. In such situations, the termination and notification will be immediate.

A certified letter of the proposed termination will be mailed with an explanation for the proposed termination, and the practitioner/provider's right to appeal the proposed termination by requesting a fair hearing.

The fair hearing request from the practitioner/provider must be in writing and received within thirty (30) calendar days following receipt of the notification letter. Failure to submit such a request within thirty (30) calendar days constitutes a waiver of any right to appeal.

If the practitioner/provider requests a fair hearing, the Chief Medical Officer will schedule and arrange for the fair hearing. The date of commencement of the fair hearing will not be less than thirty (30) calendar days from the notification letter, no more than sixty (60) calendar days from the date of receipt of the request for the fair hearing from the Provider. The Chief Medical Officer will select the individuals to serve on the Hearing Committee. The Hearing Committee will consist of at least three (3) but no more than five (5) practitioners/providers, and will include whenever feasible at least one (1) individual practicing in the same specialty as the affected

practitioner(s)/provider(s). The decision of the Hearing Committee will be final and not subject to further internal fair hearings. At a provider fair hearing, a provider has the right to:

- Attend the fair hearing;
- If the practitioner/provider cannot appear in person at the hearing, the provider will be given the opportunity to communicate with the board by conference call;
- Present his/her case to the fair hearing board;
- Submit supporting material both before and at the hearing;
- Ask questions of any representative of Molina Healthcare who attends the hearing;
- Be represented by an attorney or by any other person of the provider's choice (at the provider's expense); and
- Receive an expedited fair hearing in those instances where Molina Healthcare has not provided advance written notice of termination to the provider because Molina Healthcare has a good faith and reasonable belief that further care by the provider could result in imminent and significant harm to a Member.

Within thirty (30) calendar days of the conclusion of the fair hearing, the Hearing Committee will provide a written decision and report. The decision of the Hearing Committee will be made by majority vote. Upon receipt of the Hearing Committee's decision, the Chief Medical Officer will either adopt or reject the Hearing Committee's proposed decision. The Chief Medical Officer's action constitutes the final decision.

Although an external hearing process does not exist for a Provider, any practitioner/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.

**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**

Section 11 – Requirements for Long Term Care Service Providers

Molina Healthcare’s Care Coordinators are responsible for authorizing approved services for Long Term Care practitioners/providers. The practitioner/provider must submit an authorization request with all appropriate CPT and ICD codes.

All Long Term Care Practitioners/Providers must obtain a prior authorization before providing services to an eligible Member or prior to admitting an eligible member to their facility. All Skilled Nursing Facilities must submit a prior authorization request to Molina Healthcare for approval of nursing facility services.

The practitioner/provider is responsible for contacting the care coordinator to extend services beyond the initial authorization period. The practitioner/provider must complete a re-authorization form and send it to Molina Healthcare for re-authorization. The practitioner/provider must verify member eligibility on a monthly basis.

Home and Community Based Service (HCBS) Providers

Eligible independent practitioners/providers and provider agencies must have been approved by Medical Assistance Division (MAD) or its designees. Practitioners/providers may subcontract only with individuals who are qualified and must follow the general contract provisions and NMAC Regulations for subcontracting.

Assisted Living Facility Providers

Assisted living services can be provided only by an eligible assisted living facility. An assisted living facility must:

- Meet all the requirements and regulations, and be licensed by Department Of Health (DOH) as an adult residential care facility pursuant to 7.8.2 NMAC;
- Provide a home-like environment; and
- Comply with the provisions of Title II and III of the Americans with Disabilities Act (ADA).

Adult Day Health Provider Agencies

Adult day health services can be provided only by eligible adult day health agencies. Adult day health facilities must:

- Be licensed by the Department Of Health (DOH) as an adult day care facility;
- Meet all requirements and regulations set forth by DOH as an adult day care facility;

- Comply with the provisions of Title II and III of the Americans with Disabilities Act of 1990, (42 U.S.C. Section 12101 et seq.); and
- Comply with all applicable city, county or state regulations governing transportation services.

Environmental Modifications Providers

Environmental modification services can be provided only by eligible environmental modification agencies. An environmental modification provider must have a valid New Mexico Regulation and Licensing Department, Construction Industries Division, GB-2 class construction license pursuant to the Construction Industries Licensing Act NMSA 1978, Section 60-13-1 et seq. An environmental modification provider must:

- Comply with all New Mexico state laws, rules, and regulations, including applicable building codes, and the laws and regulations of the Americans with Disability Act Accessibility Guidelines (ADAAG), the Uniform Federal Accessibility Standards (UFAS), and the New Mexico state building code; and
- Provide at a minimum, a one-year warranty on all parts and labor.

Emergency Response Providers

Emergency response services can be provided only by eligible emergency response agencies. An emergency response provider must comply with all laws, rules and regulations of the New Mexico state public corporation commission for telecommunications and security systems, if applicable. [8.307.18.10 NMAC - N, 12-15-10; Repealed, 10-15-12]

Critical Incident Reporting

The New Mexico Human Services Division/Medical Assistance Division/Quality Bureau (HSD/MSD/QB) incident management system describes the statewide reporting requirement for all incidents involving recipients served under the Centennial Care Home and Community Benefits and Self Directed Benefits. Community agencies providing these Home and Community based services are required to report critical incidents to HSD using HSDs Critical Incident Management Website (<https://criticalincident.hsd.state.nm.us>). All reports of Abuse, Neglect and Exploitation as well as other reportable incidents; Death, Emergency Services, law Enforcement Involvement and Environmental Hazards must be submitted through the website. **Submitting an Incident Report regarding abuse, neglect or exploitation does not relieve a contracted practitioner/provider of mandated reporting requirements to APS, CPS, CYFD or other agencies.**

Any of the following type of incidents required to report:

- **Abuse** – The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a recipient;
- **Neglect** – The failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness to a recipient;
- **Self-Neglect** – An act or omission by an incapacitated adult that results in the deprivation of essential services or supports necessary to maintain minimal mental, emotional, or physical health and safety;
- **Exploitation** – The deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a recipient’s belongings or money without the recipient’s consent;
- **Unexpected Death** – Death caused by an accident or an unknown or unanticipated cause. Deaths that are suspected of being related to abuse or neglect must be reported immediately to Adult Protective Services (APS);
- **Natural/ Expected Death** – Death caused by a long-term illness, a diagnosed chronic medical condition, or other natural/expected conditions resulting in death. Natural/Expected deaths do not need to be reported to Adult Protective Services (APS);
- **Environmental Hazard** – An unsafe condition that creates an immediate threat to life or health of a recipient;
- **Law Enforcement Intervention** – The arrest or detention of a person by a law enforcement agency, involvement of law enforcement in an incident or event, or placement of a person in a correctional facility;
- **Emergency Services** – The provision of emergency services to a recipient that result in medical care that is not anticipated for this recipient and that would not routinely be provided by a primary care practitioner; and
- **Alleged Fraud** – Any reason to believe that fraud has been committed or that waste or abuse of Medicaid funds is part of the incident.

Agencies that do not comply with the incident reporting requirements are in violation of state statutes 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 the Behavioral Health Collaborative, New Mexico Department of Health, (Child Protective Services and Adult Protective Services).

Molina Healthcare will include this information as part of its ongoing provider trainings, as well as specific Agency/Provider technical assistance as requested or required. For more information please 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.

Section 12 – Provider Responsibility / Participation Requirements

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:

- 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;
- 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;
- Upon request, the PCP is required to provide the Member information about the PCP's education, training, applicable certification, and any subspecialty;
- 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;
- 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;
- Use outpatient surgical services whenever medically appropriate;
- Advise the Member of advance directive processes available. The Member can obtain forms by calling our Member Service Department;
- 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

- 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.

Specialist as PCP

A Member may select a Specialist as PCP if clinically appropriate and if the specialist agrees to provide PCP services. Members are advised during the enrollment process 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.

- Psychiatrists are the only behavioral health practitioners who qualify and may serve as PCPs.

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.

Long Term Care Provider Responsibilities

A practitioner/provider who furnishes long term care services to a Centennial Care eligible recipient must comply with all federal and state laws, regulations, and executive orders relevant to the provision of services as specified in the MAD provider participation agreement. A practitioner/provider also must conform to MAD program rules and instructions as specified in the provider rules manual and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions for billing and for authorization of services.

General Provider Responsibilities

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. Additional information regarding Adult Protective Services can be found on their website at: [Adult Protective Services](#)

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.

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 send 30 days in advance.

Compliance with cost-sharing requirement

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 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.

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

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 Healthcare'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, practitioner/provider 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**.

Disease Reporting

As required by the State of New Mexico Human Services Department, all participating providers are required to report all applicable diseases as listed in the Modifiable Diseases/Conditions in New Mexico. The provider will notify the State Office of Epidemiology at **(505) 827-0006** regarding confirmed or suspected communicable diseases, infectious diseases, and health conditions related to environmental exposures and certain injuries, sexually transmitted diseases and cancer.

All reports must include the following:

- The disease or problem being reported;
- Patient's name, date of birth, age, gender, race/ethnicity, address and telephone number;
- Practitioner/physician's (or laboratory) name, NPI number and telephone number; and
- Other conditions of public health importance.

Documentation in the Medical Record

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.

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 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?

Employee Abuse Registry Act

All participating practitioners/providers covered by the Employee Abuse Registry Act, (NMSA 1978 Sections 27-7A-1 to 27-7A-8) are required to inquire the Department of Health's Employee Abuse Registry as to whether an employee included in the Registry before hiring or contracting with the employee.

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.

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.

Fraud, Waste and Abuse Responsibilities

Molina Healthcare 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 has therefore implemented a plan to detect, prevent, investigate, and report suspected health care fraud, waste, and abuse in order to reduce health care cost and to promote quality health care.

Molina Healthcare is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, Molina Healthcare's Compliance Department maintains a comprehensive plan, which addresses how Molina Healthcare will uphold and follow state and federal statutes and regulations pertaining to fraud, waste, and abuse. Molina Healthcare's **Special Investigation Unit (SIU)** 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.

Fraud is defined as an intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to oneself or some other person. This includes any act that constitutes fraud under applicable federal or state law.

Waste is defined as 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. 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.

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

Who Commits Health Care Fraud, Waste and Abuse?

Anyone can commit fraud, waste and abuse. The SIU will investigate any allegation involving a practitioner/provider, Member, or other entity that is suspected of having committed health care fraud, waste or abuse. Molina Healthcare will seek criminal prosecution and/or civil damages in cases where fraud, waste or abuse may have occurred.

Member Fraud, Waste and Abuse Examples

The types of questionable Member schemes investigated by Molina Healthcare include, but are not limited to, the following:

- Benefit sharing with persons not entitled to the Member's benefits;
- Conspiracy to defraud Medicaid or other government programs;
- Co-Payment evasion;
- Doctor shopping, which occurs when a Member consults a number of providers for the purpose of inappropriately obtaining services;
- Falsifying documentation in order to get services approved;
- Forgery related to health care;
- Identity theft;
- Improper coordination of benefits (e.g., Member fails to disclose multiple coverage policies);
- Inappropriately utilizing transportation benefit;
- Misrepresentation of status by providing false personal information in order to illegally receive a benefit;
- Prescription diversion, which occurs when a Member obtains a prescription from a provider for a condition that he/she does not suffer from and the Member sells the medication to someone else;
- Prescription stockpiling is when a Member attempts to inappropriately use his/her drug coverage by obtaining and storing large quantities of drugs to avoid out-of-pocket costs, to protect against period of non-coverage, or for purposes of resale on the black market;
- Polypharmacy abuse, which occurs when a Member is obtaining narcotics or other drugs from multiple pharmacies in order to cover-up his/her drug seeking behavior; and/or
- Seeking services the Member is not eligible to receive.

Practitioner/Provider Fraud, Waste and Abuse Examples

The types of questionable provider schemes investigated by Molina Healthcare include, but are not limited to, the following:

- Altering paper or electronic claim forms, and/or or medical record documentation in order to get a higher level of reimbursement;
- Balance billing a Member for covered services. This includes asking the Member to pay the difference between the discounted and negotiated feeds, and the provider's usual and customary fees;

- Billing for a service using a credentialed/contracted provider when the provider who rendered services was not credentialed/contracted. (This does not impact locum tenens services that follow the appropriate guidelines);
- Billing and providing for services to Members that are not medically necessary;
- Billing for services, procedures, and or/supplies that have not been rendered or provided;
- Completing Certificates of Medical Necessity for Members not personally and professionally known by the provider;
- Concealing a Member's misuse of a Molina identification card;
- Failing to report a Member's forgery or alteration of a prescription or other medical document;
- False coding in order to receive or maximize reimbursement;
- Inappropriate billing of modifiers in order to receive or maximize reimbursement;
- Inappropriate billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement;
- Knowingly and willfully referring patients to health care facilities in which or with which the provider has a financial relationship for designated health services, which could be in violation of the Stark Law;
- Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients;
- Not following incident to billing guidelines in order to receive or maximize reimbursement;
- Overutilization;
- Participating in schemes that involve collusion between a provider and a Member that result in higher costs or charges;
- Questionable prescribing practices;
- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code;
- Underutilization, which means failing to provide services that are medically necessary;
- Up coding, which is when a provider does not bill the correct code for the service rendered, and instead uses a code for like services that cost more; and/or
- Using the adjustment payment process to generate fraudulent payments.

Cooperating with SIU Activities

Molina Healthcare's SIU may conduct prepayment, concurrent, or post-payment review. Practitioners/providers will cooperate with SIU activities, and will provide requested documentation to the SIU following the timelines indicated in such requests. Failure to cooperate may result in further action, up to and including termination of the provider contract.

Reporting Fraud, Waste and Abuse

If you suspect fraud, waste, or abuse, you must notify Molina Healthcare. Referring entities have the right to remain anonymous without fear of retaliation. Information reported to Molina Healthcare will remain confidential to the extent possible as allowed by law.

Molina Healthcare expressly prohibits retaliation against those, who in good faith, report potential fraud, waste and abuse. If you suspect health care fraud, waste and abuse, you may report the situation in writing or by telephone using the Molina Healthcare AlertLine, which is available at any time (day or night), weekends, and holidays.

To report an issue by telephone, call toll free: (866) 606-3889

To report an issue online, visit <https://molinahealthcare.AlertLine.com>

When reporting an issue, please provide as much information as possible. The more information provided to the Molina Healthcare AlertLine, the better the chances the situation will be successfully reviewed and resolved. Information that should be reported includes:

- **Allegation** – A complete description of the allegation, including the type of fraud, waste, or abuse (e.g., balance billing, falsification of information, billing for services not rendered).
- **Suspect's Identity** – The names, including any aliases or alternative names, of individuals and/or entities involved in suspected fraud, waste, or abuse, including address, telephone number, email address, Medicaid identification number, and any other identifying information.
- **Date(s) of Occurrence** – When did the fraud, waste, or abuse happen? Provide dates and times.

You may also report Medicaid fraud to:

**Medical Assistance Division
Quality Assurance Bureau
P.O. Box 2348
Santa Fe, NM 87504-2348
NMMedicaidFraud@state.nm.us
Local in 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**

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

The Deficit Reduction Act (DRA) of 2005 aims to cut fraud, waste, or abuse from the Medicare and Medicaid programs. Under the DRA, health care entities who receive or pay out at least \$5 million in Medicaid funds per year must now comply with DRA Section 6032, Employee Education about False Claims Recovery. This section maintains that these entities must have written policies for all employees, contractors and agents that provide **detailed** information in terms of:

- The Federal False Claims Act and any state laws pertaining to civil or criminal penalties for false claims and statements, including whistleblower protections granted in these laws;

- How the provider will detect and prevent fraud, waste, and abuse; and
- The rights of the employee to be protected as whistleblowers and reiteration of the entity's policy for detecting and preventing waste, fraud, and abuse in the employee handbook.

The Federal False Claims Act, 31 U.S.C. § 3279, establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the United States government for payment or approval. To better understand the intent of the Federal False Claims Act, terms like “knowing” and “knowingly” mean that a person, with respect to information:

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

The Federal False Claims Act also holds any person liable who engages in the following actions:

- Knowingly makes, uses or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved;
- Conspires to defraud the government by getting a false or fraudulent claim allowed or paid;
- Has possession, custody, or control of property or money used, or to be used, by the Government and, intending to defraud the government or willfully conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receive a certificate or receipt;
- Authored to make or deliver a document certifying receipt of property used, or to be used, by the government, and, intending to defraud the government, makes or delivers the receipt without completely knowing the information on the receipt is true;
- Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the government who lawfully may not sell or pledge the property; and/or
- Knowingly makes uses or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government.

Persons who have engaged in the acts described are liable to the government for a civil penalty. The penalty is not less than \$5,000 and not more than \$10,000 plus three times the amount of damages the government sustains because of the act of that person. The only exceptions made would be if it were found the person who committed the violation furnished government officials responsible for investigating false claims violations with **all** information known about the violation within thirty (30) days after the date on which the person who committed the act first obtained the information. The violator must then fully cooperate with any government investigation. In addition, at the time the violator furnishes the government with the information about the violation, no criminal prosecution, civil action, or administrative action must have taken place, and the violator did not have actual knowledge of the existence of an investigation into the violation. In such a situation, the court would assess the matter at not less than two times the amount of damages. However, the violator would still be liable to the government for the costs of a civil action brought to recover any such penalty or damages.

It is important to note that the Act does not require proof of a specific intent to defraud the United States government or its agents. Health care providers and organizations can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims.

Like the Federal False Claims Act, the Medicaid False Claims Act has a Qui Tam “Whistleblower” provision with specific employee protections. The provision encourages employees (current or former) and other interested parties with information involving false claims to report these incidents to the government. The government may proceed to file a lawsuit against organizations accused of violating the False Claims acts on behalf of the individual who reported the violation. Or, the whistleblower may take this information and file a lawsuit on his/her own behalf. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

The Medicaid False Claims Act contains overlapping language in terms of a person’s liability for certain acts. However, Article 14 differences, in terms of liability, are as follows:

- Presents or causes to be presented to the state a claim for payment under the Medicaid program knowing that the person receiving a Medicaid benefit or payment is not authorized or is not eligible for a benefit under the Medicaid program;
- Knowingly applies for and receives a benefit or payment on behalf of another person, except pursuant to a lawful assignment of benefits, under the Medicaid program and converts that benefit or payment to his own personal use;
- Knowingly makes a false statement or misrepresentation of material fact concerning the conditions or operation of a health care facility in order that the facility may qualify for certification or recertification required by the Medicaid program; and/or
- Knowingly makes a claim under the Medicaid program for a service or product that was not provided.

Health care entities should also pay special note to Article 14 Section 7, civil action for false claims, and Section 9, Award to qui tam plaintiff. These sections describe in detail how the State may pursue civil actions against those who defraud the Medicaid system; and, the monetary awards whistleblowers may be entitled to for bringing a false claims issue to the attention of the government.

Employee protections are provided in Section 12. The section states employees who have been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to his/her role in furthering a false claims action are entitled to all relief necessary to make the employee whole. An employee turned whistleblower is entitled to:

- Employment reinstatement at the same level of seniority;
- Two times the amount of back pay;
- Interest on back pay; and
- Compensation for special damages incurred by the employee because of the employer’s inappropriate actions.

By making health care entities responsible for putting these laws into practice within their business, these entities can no longer state they were not aware of false claims laws and what these laws mean.

Affected entities who fail to implement and comply with DRA Section 6032 will be at risk of forfeiting all Medicaid payments until compliance is met. Molina Healthcare Compliance will monitor applicable Molina Healthcare providers to ensure they are complying with Section 6032 standards.

For more information on this legislation, please contact your Molina Healthcare Member Services Representative in Albuquerque at (505) 341-7493 or toll free at (888) 825-9266.

Together, our efforts can prevent fraud, waste and abuse.

Gross Receipts / Sales Tax

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>

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

Joining or Leaving a Practice

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

Joining a Practice:

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 you 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.

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) and 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.

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.

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.

Promotional Activities

At the request of Molina Healthcare, Providers will (i) 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.

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.

Providing and Measuring Access to Medical Care

Molina Healthcare 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) <ul style="list-style-type: none"> ▪ Urgent ▪ Non-urgent <ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ 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 <ul style="list-style-type: none"> ▪ Average Speed to Answer ▪ Average Abandonment Rate ▪ Answer ninety-five percent (95%) of Member calls 	<ul style="list-style-type: none"> ▪ ≤ Thirty (30) seconds ▪ ≤ Five percent (5%) ▪ ≤ Thirty (30) seconds

Molina Healthcare is committed to providing its Members with accessible, timely, quality health care and services.

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.

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.

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, Anti-Fraud Program, Complaints and Appeals, 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.

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, you can also see the New Mexico Immunization Program's website at:** www.immunizenm.org; 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>.

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 – Preventive Health Guidelines and Standards

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 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

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.

*These items must be documented in order to fulfill the requirement of an EPSDT exam. Bullets 1-3 must be documented in order to meet HEDIS criteria. For EPSDT documentation tools please refer to the Appendix for recommended preventive health visit forms for birth – twenty (20) years.

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 such reminders through its monthly Patient Appointment Reminder Card for children and adults with corresponding practitioner panel reports.

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.

Claims Processing

Submit the Centers for Medicare & Medicaid Services (CMS)-1500 (08/05) form with the encounter code from the following codes:

Group A - Preventive Medicine Services

99381	New patient under one (1) year
99382	New patient (ages one [1] to four [4] years)
99383	New patient (ages five [5] to eleven [11] years)
99384	New patient (ages twelve [12] to seventeen [17] years)
99385	New patient (ages eighteen [18] to thirty-nine [39] years)
99391	Established patient under one (1) year
99392	Established patient (ages one [1] to four [4] years)
99393	Established patient (ages five [5] to eleven [11] years)
99394	Established patient (ages twelve [12] to seventeen [17] years)
99395	Established patient (ages eighteen [18] to thirty-nine [39] years)
99431	Newborn care (history and examination)
99432	Normal newborn care

Group B - Evaluation and Management Codes

99201-99205	New Patient
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99211-99215 Established Patient

Diagnosis Codes Used with Group B

V20.0 through V20.2, V70.0 or V70.3 through V70.9

Immunizations Codes

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

Practitioners shall 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.

Pregnancy Identification Codes

Practitioners are encouraged to provide notification of pregnancy for Molina Healthcare Members. Notify Molina Healthcare within seventy-two (72) hours following the visit where pregnancy is determined. Molina Healthcare will reimburse contracted Primary Care Practitioners and Obstetrics/Gynecology Practitioners when notification is received within this time period. Submit a Prior Authorization Request Form for notification and to report and bill for these services; please use CPT-4 code 59899 and ICD-9 code V72.42.

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

By one month
At two months
4 months
6 months

9 months

Early Childhood

12 months
15 months
18 months
24 months
30 months (developmental screen)
3 years

Middle Childhood

4 years
5 years
6 years
8 years
10 years

Adolescence

12 years
13 years
14 years
15 years
16 years
17 years
18 years
19 years
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 Toolkit

Molina Healthcare has provider toolkits 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 the EPSDT

Provider Toolkit, call the Health Improvement Hotline in **Albuquerque at (505) 342-4660 ext. 182618 or toll free at (800) 377-9594 ext. 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 ext. 182618 or toll free at (800) 377-9594 ext. 182618.**

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?

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?

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.**

Section 14 – Privacy Practices -Health Insurance Portability and Accountability Act (HIPAA)

Molina Healthcare’s Commitment to Patient Privacy

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

Provider 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.

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.

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;
 - Disease 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.

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.

Written Authorizations

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

Patient Rights

Patients are afforded various rights under HIPAA. Molina Healthcare providers 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.

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.

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.

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.

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.

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 15 – Claims and Reimbursement

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.

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.

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](#)

“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 – please refer to Section K-5;
- Valid modifiers (if appropriate); and
- All other requirements as specified in Subsection L of 8.305.1.7 NMAC.

***Telehealth providers: Telehealth service codes must be included.**

Coordination of Benefits (COB)

Practitioners/providers should maintain current coverage information on all Members.

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 (the payor 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 payor 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 (2) plans cover the same child as a dependent (parents are separated or divorced), the primary payor is determined in this order:
 - First (1st), the plan of the parent who has custody of the child;
 - Second (2nd), the plan of the spouse of the parent who has custody of the child;
 - Third (3rd), 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.

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 payor'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 payor's EOB. The primary payor's EOB must match the submitted claim, and include descriptions of all associated remit messages so that Molina Healthcare may appropriately consider the charges.

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.

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.

Key to EOB Messages

Explanation of benefits (EOB) is defined on the EOB document sent with claims (i.e. payments, adjustments, denials, etc.). Please 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).

Claim Resubmission/Adjustments

ALL requests must include any/all documentation to support the request. The Provider Reconsideration Review Request Form (PRR) is included in this Section for your convenience.

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 payor 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 payor.

All corrected claims must provide an indicator on the CMS-1500 form in Box 22/ 22a and Box 19:

- **Box 22/22a:** Must indicate the original Claim Number/Identification to avoid being denied as a duplicate claim; and
- **Box 19:** Indicate that the claims is a “Corrected Claim.”

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 payor (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.

Claim Edits

Molina Healthcare is contracted with HealthCare Insight (HCI) to perform prepayment claim audits. HCI uses Medicare (i.e., CMS) claim edits and other industry standard coding guidelines (i.e., Current Procedural Terminology (CPT) & Health Care Procedure Coding System (HCPCS)) to ensure proper handling of claims.

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](#)

An explanation of Claims EOB Messages can be found in the Appendix.

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;
- **Denied emergency room claims:** A Member is responsible for payment of a hospital outpatient emergency room visit if it is determined that an emergency did not exist at the time the service was provided. The Member may only be billed for the emergency room charges if they have signed a waiver at the hospital stating they will be responsible for the charges if it is determined that an emergency did not exist. A Member cannot be billed for the ancillary charges (i.e. laboratory & radiology services); 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.

Enhanced Payments for Primary Care Services

In accordance with section 1202 of the PPACA and implementing regulations, Molina Healthcare has mechanisms in place to reimburse certain evaluation and management services and immunization administration services furnished in calendar year 2014 by a physician 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.

Electronic Funds Transfer (EFT) / Electronic Remittance Advice (ERA)

EDI Payer ID: New Mexico Clearing House Information:

Name	Phone Number	Transaction Type/Format	Payer ID
Emdeon	(800) 296-3736	HCFA 1500 - Professional (837P) UB 92 - Institutional (837I) Eligibility Inquiry/Response (270/271) Claims Status Inquiry/Response (276/277)	09824

The Companion Guide and other EDI information can be obtained on our website: [Molina Healthcare EDI Information and Materials](#)

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 for instructions to register.

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.

An overpayment will be deemed to have been “identified” when a practitioner/provider:

- Reviews billing or payment records and learns that it incorrectly coded certain services, resulting in increased reimbursement;
- Learns that a patient death occurred prior to the service date on which a claim that has been submitted for payment;
- Learns that services were provided by unlicensed or excluded individual on its behalf;
- Performs an internal audit and discovers that an overpayment exists;
- Is informed by a government agency of an audit that discovered a potential overpayment.
- Is informed by Molina Healthcare of an audit that discovered a potential overpayment;
- Experiences a significant increase in Medicaid revenue and there is no apparent reason – such as a new partner added to a group practice or new focus on a particular area of medicine – for the increase;
- Has been notified that Molina Healthcare or a government agency has received a hotline call for email; and/or
- Has been notified that Molina Healthcare or a government agency has received information alleging that a recipient had not received services or been supplied goods for which the provider submitted a claim for payment.

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:

1. Provider’s name;
2. Provider’s tax identification number and National Provider Number;
3. How the overpayment was discovered;
4. The reason for the overpayment;
5. The health insurance claim number, as appropriate;
6. Date(s) of service;
7. Medicaid claim control number, as appropriate;
8. Description of a corrective action plan to ensure the Overpayment does not occur again;
9. 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;
10. The specific dates (or time-span) within which the problem existed that cause the overpayments;
11. If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment; and
12. The refund amount.

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. The provider may:

1. request that the CONTRACTOR permit installment payments of the Refund, such request be agreed to by the CONTRACTOR and the Provider; or
2. 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.

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.

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 and will research, resolve, track and trend issues. Confirmed Adverse Events/Never Events are reportable when related to an error in medical care that is clearly identifiable, preventable and/or found to have caused serious injury or death to a patient.

If it is determined that a HAC has occurred, payment will be denied. In such instances, please note that the practitioner/provider is not allowed to bill the Member.

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.

Section 16 – Member 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. **Providers' complaint and appeal processes can be found at the end of this section.**

- 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.

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.

Filing a Formal Verbal or Written Complaint or Appeal for Members

Molina Healthcare's Appeals Department for Members and providers is also known internally as the Member/Provider Inquiry, Research and Resolution 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 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.

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.

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.**

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 (30th) 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.

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.

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.

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.

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.	<ul style="list-style-type: none"> ➤ 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.	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ 72 hours - Written decision notice and best effort to provide oral

	provider.	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.	<ul style="list-style-type: none"> ➤ 5 business days - Acknowledgement is sent to the Member after receipt of the request ➤ 30 calendar days - To resolve the issue
Review Extension	When the Member requests the extension or Molina Healthcare can demonstrate the need for additional information.	<ul style="list-style-type: none"> ➤ 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 17 - 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.

1. **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

2. **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.
3. 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.
4. 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.
5. 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.
 6. 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 “Member/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;
 - Notification to the provider of the appeal process;
 - 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.
 7. The Appeals Department coordinates relaying provider grievance and appeal information to internal quality improvement committees.
 8. 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	<ul style="list-style-type: none"> • Filing Limit: Ninety (90) calendar days from the date of dissatisfaction. • Resolution: No more than thirty (30) calendar days from receipt.
Appeals	<ul style="list-style-type: none"> • Filing Limit: Ninety (90) calendar days from the date of notice of action. • Resolution: Thirty (30) calendar days from receipt.

9. 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.

10. 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.

11. The provider will not be subject to retaliation for filing a grievance or appeal.

12. Upon receipt, the issue is reviewed by the Appeals staff and the grievance or appeal is processed accordingly.

13. Molina Healthcare will maintain confidential locked files located in the Appeals Department, or secure electronic files, for all issues received.

14. 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.

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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.

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:

[Provider Reconsideration Review Request 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 toll free at (888) 825-9266** and a representative will be glad to assist you.

Section 18 – 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 Disease Management Program information, contact the Health Improvement Hotline in **Albuquerque at (505) 342-4660, extension 182618 or toll free at (800) 377-9594, extension 182618.**

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 Center 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.

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 Medicaid 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.

Telehealth best practice adherence will be measured through consumer surveys and/or site visits.

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.

We welcome and encourage 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.

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 include 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.

HEDIS[®] & CAHPS[®]

Measurement of Clinical and Service Quality

- Health Effectiveness Data and Information Set (HEDIS[®])
- Consumer Assessment of Healthcare Providers and Systems (CAHPS[®])

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; and
- Blood Lead Screening.

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.

Your office may be requested to submit documentation from medical files as part of the HEDIS[®] data collection process. The most recent HEDIS[®] results for Molina Healthcare can be found by following this link on our website: [HEDIS Results](#)

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.

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 Coding Brochures that are available on the Molina Healthcare Provider Portal: [HEDIS Coding Brochure](#). Electronic submission of health data on our membership with appropriate coding will reduce the need for hybrid chart abstraction.

Section 19 – Clinical Practice Guidelines

Clinical Practice Documents are available for review and printing on the Molina Healthcare website at www.molinahealthcare.com in the Clinical Practice Guideline section. [As of April, 2013, specific Long Term Care Clinical Practice Guidelines are being developed.]

If you do not have internet capability a hard copy of the clinical practice guideline can be mailed to you. Contact Provider Services in Albuquerque (505) 342-4660 or toll free (800) 377-9594.

Asthma

Clinical Practice Guideline: Stepwise Approach for Managing Infants Young Children and Adults with Asthma

Molina Healthcare of New Mexico, Inc. (Molina Healthcare) has approved the U.S. Department of Health and Human Services, National Heart Lung and Blood Institute (NHLBI) Guideline for Managing Infants, Young Children and Adults with Asthma at:

<http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.pdf>.

The following documents are also available.

- Sample Asthma Action Plans for patients in both English and Spanish;
- A list of Durable Medical Equipment (DME) suppliers who can assist your practice in stocking an Asthma Closet; and
- A brochure detailing how to contact the University of New Mexico Telehealth clinic (Project ECHO [Extension for Community Healthcare Outcomes]) for assistance from pulmonary specialists on individual cases.

Behavioral Health

Molina Healthcare has approved the American Psychiatric Association Clinical Practice and the American Academy of Child and Adolescent Psychiatry Clinical guidelines for Children, Adolescents and Adults. These guidelines are available at:

<http://www.guideline.gov/browse/by-organization.aspx?orgid=360Bronchitis>

Clinical Practice Guideline: Management of Uncomplicated Acute Bronchitis in Adults

Molina Healthcare has approved the Michigan Quality Improvement Consortium guideline for Management of Uncomplicated Acute Bronchitis in Adults. This guideline is available at: <http://www.guideline.gov/content.aspx?id=38688>

Coronary/Vascular Disease

Clinical Practice Guideline: Secondary Prevention for Patients with Coronary and Other Vascular Disease

Molina Healthcare has approved the National Heart Lung and Blood Institute (NHLBI) guideline for Secondary Prevention for Patients with Coronary and Other Vascular Disease guidelines. These guidelines are available at <http://circ.ahajournals.org/content/113/19/2363.full>

Diabetes Mellitus

Clinical Practice Guideline: New Mexico Healthcare Takes on Diabetes Collaborative

Molina Healthcare has approved the New Mexico Healthcare Takes on Diabetes Practice Guidelines for diabetes management. This guide is available at: <http://nmtod.com/pdfs/Profguideline2013final.pdf>

Hypertension

Clinical Practice Guideline: Diagnosis and Management of Hypertension in Adults and Children

Molina Healthcare has approved the U.S. Department of Health and Human Services, National Heart Lung and Blood Institute (NHLBI) guidelines for Diagnosis and Management of Hypertension in Adults and Children. These guidelines are available at: <http://www.nhlbi.nih.gov/guidelines/hypertension/index.htm>

Individuals with Special Health Care Needs

Therapies for Individuals with Special Health Care Needs

Molina Healthcare has approved the American Academy of Pediatrics guideline for Therapies for Individuals with Special health Care Needs. These guidelines are available at: <http://pediatrics.aappublications.org/content/113/6/1836.full>

Low Back Pain

Clinical Practice Guideline: Management of Uncomplicated Acute Low Back Pain in Adults

Molina Healthcare has approved the Michigan Quality Improvement Consortium Management of Acute Low Back Pain Guideline. This guideline is available at:

<http://www.guideline.gov/content.aspx?id=39319>

Obesity / Overweight

Clinical Practice Guideline: Prevention and Treatment of Adult Overweight and Obesity in Primary Care

Molina Healthcare has approved the National Institutes of Health National Heart, Lung, and Blood Institute guideline for Prevention and Treatment of Adult Overweight and Obesity in Primary Care. This guideline is available at: <http://www.nhlbi.nih.gov/guidelines/obesity>.

Otitis Media

Clinical Practice Guideline Diagnosis and Management of Acute Otitis Media

Molina Healthcare has approved the American Academy of Pediatrics and the American Academy of Family Physicians Subcommittee on Management of Acute Otitis Media guidelines. These guidelines are available at:

<http://pediatrics.aappublications.org/content/113/5/1451.full?sid=a20acfe5-299f-46b4-9703-fa1cc33f4451>

Upper Respiratory Illness

Diagnosis and Treatment of Upper Respiratory Illness and Pharyngitis in Children and Adults

Molina Healthcare has approved the Institute for Clinical Systems Improvement (ICSI) guidelines for Diagnosis and Treatment of Upper Respiratory Illness and Pharyngitis in Children and Adults. These guidelines are available at: https://www.icsi.org/_asset/1wp8x2/RespIllness.pdf

Appendix – CMS 1500

For professional providers who submit paper claims, the Centers for Medicare & Medicaid Services (CMS)-1500 (08/05) form is required. When submitting the CMS-1500 form, be sure all applicable fields are completed, including your NPI. Claims with missing or invalid required fields will be rejected and returned for correction and re-submission.

EDI/Electronic submissions are included in the requirements listed below.

The blocks with an asterisk (*) are required, if applicable.

Block 1:

Type of Health Insurance

Show the type of health insurance coverage applicable to this claim by checking the appropriate box.

Block 1A*: Insured's Unique ID Number Assigned by the Payor Organization.

Enter the ID number of the Member exactly as shown on the identification card.

EDI - Enter the ID number of the Member exactly as shown on the ID card minus the dashes.

Block 2*:

Patient's Name

Enter the last name, first name, and middle initial (if known) of the patient exactly as shown on the identification card.

Block 3*:

Patient's Birth Date and Gender

Enter the month, day, and year of the patient's birth. Check the appropriate box to identify the patient's Gender.

Block 4*:

Insured's Name

Enter the last name, first name and middle initial of the Member as shown on the identification card (ID). If the patient is the insured, enter the word "same".

Block 5*:

Patient's Address

Enter the patient's complete address and telephone number (if available).

Block 6:

Patient's Relationship to Insured

Check correct box: self, spouse, child or other.

Block 7:

Insured's Address

Complete if patient is not the Member and phone number (if available).

Block 8:

Patient status

Check the appropriate box(s).

Block 9*:

Other Insured's Name

Enter the name of the insured with the name of his/her insurance company.

Block 9A*:

Other Insured's Policy or Group Number

Enter the policy and/or group number of the other insurance coverage.

Block 9B:

Other Insured's Date of Birth

Enter the information available to you.

Block 9C*:

Employer's Name or School Name

Enter the complete name.

Block 9D*:

Insurance Plan Name or Program Name

Enter the name of the insurance plan.

Block 10:

Is Patient's Condition Related?

Check the correct boxes in a., b. and c.

Block 10D:

Reserved For Local Use

Leave Blank.

Block 11*:

Recipient's Group Number

Enter the identification number, control number or code assigned by the carrier or administrator to identify the group under which the individual is covered. The group number can be found on the Member's ID card.

EDI - same as above

Block 11A:

Insured's Date of Birth and Gender

Block 11B:

Employer's Name or School Name

Block 11C:
Insurance Plan Name or Program Name

Block 11D:
Is there another Health Benefit Plan?

Block 12*:
Patient's Authorized Person's Signature
Have patient sign if your office requires.

Block 13*:
Insured's or Authorized Person's Signature
Have patient sign.

Block 14:
Date of Current Illness
Enter the date of the current illness, injury or pregnancy.

Block 15:
If Patient Has Had Same or Similar Illness
Enter the date the patient first consulted you for this condition.

Block 16:
Dates Patient Unable to Work in Current Occupation
Leave blank.

Block 17*:
Name of Referring Physician or Other Source
Show the name of the referring or ordering physician.

Block 17A:
ID Number of Referring Physician
Enter the referring Primary Care Practitioner (PCP) tax identification number (TIN) or Unique Physician Identification Number (UPIN).

Block 17B*:
NPI Number of Referring Physician
Enter the NPI.

Block 18:
Hospitalization Dates Related to Current Services
For inpatient services, enter the admission date of the hospitalization (and discharge date if available).

Block 19:
Reserved for Local Use

Additional information for paper and EDI submission. When submitting a Corrected Claim, please indicate “Corrected Claim” in this Block.

Block 20:

Outside Lab

If your patient had lab work done, check the correct box regardless of whether or not you are actually billing for the lab work. You need not list charges in this block.

Block 21*:

Diagnosis or Nature of Illness or Injury

Identify the diagnosis/condition of the patient by entering the International Classification of Diseases 9th Revision (ICD-9)-CM codes. Up to four (4) codes may be listed and should be shown in order of relevance.

The diagnosis code must be carried out to the highest degree of detail (4th or 5th digit).

Block 22:

Medicaid Re-submission – Enter Claim Number/Identification of Corrected Claim

Block 23:

Prior Authorization Number

Enter the authorization number, if applicable.

Block 24A*:

Date(s) of Service

Enter the date(s) of service. If only one service is provided, the date should be entered in “from date.” If there are multiple dates, they should be entered as a “from date” through “to date” or listed on individual lines.

Block 24B*:

Place of Service

Indicate where the services were provided by entering the appropriate two-digit place of service code. (See list in this section.)

Block 24C*:

EMG

EDI - HIPAA - Not Available

Block 24D*:

Procedure Code

Enter the most specific procedure code which best describes each service. Explaining unusual services or situations may help speed up processing of the claim. If both a Current Procedural Terminology (CPT) code and a Health Care Procedure Coding System (HCPCS) code describe the same service, submit a CPT code. Claims with missing procedure codes or modifiers will be denied for correction and re-submission. Claims billed with by report codes or miscellaneous codes, must be accompanied by appropriate documentation for consideration.

Block 24E*:

Diagnosis Pointer

Enter the diagnosis code reference number (i.e., up to four ICD-9-CM codes) as shown in Block 21, to relate the date of service and the procedures performed to the appropriate diagnosis. Show a maximum of four (4) diagnosis codes.

Block 24F*:**Charges**

Enter your charge for each listed service.

Block 24G*:**Days or Units**

Enter the number of services billed on the line. For anesthesia services report the total number of minutes and report modifier units on separate lines.

Block 24H*:**Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Family Planning****Block 24I:****ID QUAL****Block 24J:****Rendering Provider ID#**

Enter rendering provider NPI in unshaded field.

Block 25*:**Federal Tax ID Number**

Enter the provider's tax identification number as given by the Internal Revenue Service.

Block 26:**Your Patient's Account Number**

If you use patient account numbers, enter the number for this patient.

Block 27:**Accept Assignment - used for government claims refer to the back of the claim form**

Indicate whether you accept assignment.

Block 28*:**Total Charge**

Enter the total of all charges submitted on this claim.

Block 29:**Amount Paid**

Enter the amount that the patient and/or other insurance carrier has paid to you.

Block 30:**Balance Due**

Enter the difference between Block 28 and Block 29.

Block 31*:
Signature of Practitioner or Supplier (must be legible)

Block 32*:
Service Facility Location Information
Enter the name and address of facility where services were rendered.

Block 32a*:
NPI
Enter NPI.

Block 32b:
Other ID Numbers
Enter other ID numbers.

Block 33*:
Billing Provider Info - *This information must match your TIN from your W-9 form.*

Block 33a*:
Billing Provider NPI.

Block 33b:
Billing Provider Other ID numbers. (show form)

Appendix – UB-04

Completing a UB-04 Form (Copy of form can be found in this section)

For facility charges submitted on paper claims, the UB-04 form is required. When you submit the UB-04 form, be sure all applicable fields are completed. Claims with missing or invalid required fields will be rejected and returned for correction and resubmission.

EDI/Electronic submissions are included in the requirements listed below.

The blocks with an asterisk (*) are required, if applicable.

Block 1*:

Facility Name, Address, and Phone Number

The name of the provider submitting the bill and the complete mailing address to which the provider wishes payment sent. *This information must match your TIN from your W-9 form.*

Block 2:

Pay-to Name and Address

Required only if different from the data reported in Block 1.

Block 3a*:

Patient Control Number

Patient's unique alphanumeric number assigned by the provider to facilitate retrieval of individual financial records and posting of the payment.

Block 3b*:

Medical/Health Record Number

Enter the number assigned to the patient's medical or health record.

Block 4*:

Type of Bill

A three (3)-digit code indicating the specific type of bill (inpatient, outpatient, adjustments, voids, etc.)

Block 5*:

Federal Tax Identification Number (TIN)

The number assigned to the provider by the federal government for tax reporting purposes.

Block 6*:

Statement Covers Period

The beginning and ending service dates of the period included on the bill.

Block 7:

Not Used

Block 8*:

Patient Name/Identifier

a. Last name, first name, and middle initial of the patient – b. patient identification if different from the subscriber ID.

Block 9*:

Patient Address

The patient's full mailing address, including street number and name, post office box number, city, state and zip code.

Block 10*:

Patient Date of Birth

The patient's month, day and year of birth (MMDDCCYY).

Block 11*:

Patient Gender

Enter an "M" (male) or an "F" (female).

Block 12*:

Admission Date/Start of Care date

Enter the date the patient was admitted for inpatient care, outpatient services or other start of care.

Block 13*:

Admission Hour

The hour during which the patient was admitted for inpatient or outpatient care.

Block 14*:

Type of Admission

A code indicating the priority of this admission.

Block 15*:

Point of Origin for Admission or Visit

A code indicating the source of this admission. This is required for inpatient, outpatient hospital, home health and inpatient Skilled Nursing Facility claims.

Block 16:

Discharge Hour

Hour that the patient was discharged from inpatient care.

Block 17*:

Patient Discharge Status

A code indicating patient status as of the ending service date of the period covered on this bill, as reported in Block 6, *Statement Covers Period*.

Blocks 18-28*:

Condition Codes

A code(s) used to identify conditions relating to this bill that may affect payor processing.

Block 29:

Accident State

Block 30:

Not Used

Blocks 31-34:

Occurrence Codes and Dates

The code and associated date defining a significant event relating to this bill that may affect payor processing.

Blocks 35- 36:

Occurrence Span Code and Dates

A code and the related dates that identify an event that relates to the payment of the claim.

Block 37:

Not Used

Block 38:

Responsible Party Name and Address

The name and address of the party responsible for the bill.

Blocks 39-41:

Value Codes and Amounts

A code structure to relate amounts or values to identified data elements necessary to process this claim as qualified by the payor organization.

Block 42*:

Revenue Code

A code that identifies a specific accommodation, ancillary service, or billing calculation.

Block 43*:

Revenue Description

A narrative description of the related revenue categories included on this bill.

Block 44*:

HCPCS/Rates

The accommodation rate for inpatient bills and the HCPCS applicable to ancillary service and outpatient bills.

Block 45*:

Service Date

The date the indicated service was provided.

Block 46*:

Units of Service

A quantitative measure of services rendered by revenue category to or for the patient to include, but not limited to items such as number of accommodation days, miles, pints of blood, or renal dialysis treatments.

Block 47*:

Total Charges (by Revenue Code Category)

Total charges pertaining to the related revenue code for the current billing period as entered in the “statement covers” period. Total Charges includes both covered and non-covered charges.

Block 48:

Non-Covered Charges

To reflect non-covered charges for the primary payor pertaining to the related revenue code.

Block 49:

Reserved

This unlabeled field is reserved for national use.

Block 50*:

Payer Identification

- a. Payer Name Primary;
- b. Payer Name Secondary; or
- c. Payer Name Tertiary.

Block 51*:

Health Plan ID

a.b. & c. Health Plan’s ID.

Block 52*:

Release of Information Certification Indicator

A code indicating whether the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim.

Block 53*:

Assignment of Benefits Certification Indicator

A code showing whether the Provider has a signed form authorizing the third party payor to pay the Provider.

Block 54:

Prior Payments

- a. Primary;
- b. Secondary; or
- c. Tertiary.

The amount the provider has received toward payment of this bill prior to the billing date by the indicated payor.

Block 55:

Estimated Amount Due

- a. Primary;
- b. Secondary; or
- c. Tertiary.

The amount estimated by the provider to be due from the indicated payor (estimate responsibility less prior payments).

Block 56:

NPI

Provider's NPI.

Block 57:

Other Provider ID

- a. Primary;
- b. Secondary; or
- c. Tertiary.

Block 58*:

Insured's Name

- a. Primary;
- b. Secondary; or
- c. Tertiary.

Block 59:

Patient's Relationship to Insured

- a. Primary;
- b. Secondary; or
- c. Tertiary.

Block 60*:

Insured's Unique ID

- a. Primary;
- b. Secondary; or
- c. Tertiary.

Insured's unique identification number assigned by the payor organization. Enter the identification number of the Member exactly as shown on the identification card.

EDI - Enter the identification number of the Member exactly as shown on the identification card minus the dashes.

Block 61*:

Insured Group Name

- a. Primary;
- b. Secondary; or
- c. Tertiary.

Name of the group or plan through which the insurance is provided to the insured.

Block 62*:

Insurance Group Number

- a. Primary;
- b. Secondary; or
- c. Tertiary.

The ID number, control number or code assigned by the carrier or administrator to identify the group under which the individual is covered. The group number can be found on the Member's identification card.

EDI - same as above.

Block 63:

- a. Primary;
- b. Secondary; or
- c. Tertiary.

Treatment Authorization Code

A number or other indicator that designates that the treatment covered by this bill has been authorized by the payor.

Block 64:

Document Control Number

Block 65:

Employer Name

- a. Primary;
- b. Secondary; or
- c. Tertiary;

Block 66*:

Diagnosis and Procedure Code Qualifier

This code identifies the version of the Internal Classification of Diseases (ICD-9) being reported.

Block 67*:

The Principal Diagnosis Code

The ICD-9-CM codes describing the principal diagnosis. **The Diagnosis code must be carried out to the highest degree of detail (4th or 5th digit).**

Block 67A-67Q*:

Other Diagnosis Codes

The ICD-9-CM codes corresponding to additional conditions that coexist at the time of admission, or develop subsequently and which have an effect on the treatment received or the length of stay. **The Diagnosis code must be carried out to the highest degree of detail (4th or 5th digit).**

Blocks 68:
Unlabeled

Block 69*:

Admitting Diagnosis

The ICD-9-CM code provided at the time of admission as stated by the physician. **The Diagnosis code must be carried out to the highest degree of detail (4th or 5th digit.)**

Block 70*:

Patient's Reason for Visit Code

Block 71:

Prospective Payment System Code

Block 72*:

External Cause of Injury Code ("E" Code)

The ICD-9-CM Code for the external cause of an injury, poisoning, or adverse effect.

Block 73:

Unlabeled

Block 74*:

Principal Procedure Code and Date

The code that identifies the principal procedure performed during the period covered by this bill and the date on which the principal procedure described on the bill was performed.

Block 74a – 74e*:

Other Procedure Codes and Dates

The ICD-9-CM codes corresponding to additional significant procedures that are performed during the length of the stay, and the corresponding dates on which the procedures were performed.

Block 75:

Unlabeled

Block 76*

Attending Physician NPI & Name

NPI of attending physician and First and Last Name.

Block 77*:

Operating NPI & Name

NPI of operating physician and First and Last Name.

Block 78*:

Other Physician ID & Name

TIN of the licensed physician and First and Last Name.

Block 80:

Remarks

Notations relating specific state and local needs providing additional information necessary to adjudicate the claim or otherwise fulfill State reporting requirements.

Block 81:

Code-Code Field

Situational – To report additional codes related to a Form Locator or to report an external code list.

Appendix - Claims EOB Messages

Sequential order of information as shown on the Remittance Advice

Patient Name

Last name, first name, middle initial of patient

Payer Claim Ctrl#

Molina Healthcare system generated claim number

Patient Control #

Patient account number on claim

Rendering Provider Name

Servicing/Rendering provider

Health Plan

Health Plan to which the patient belongs

Service From/Service To

Dates of service specific to the claim line (From and to)

Rev Code/CPT/HCPC

Revenue Code Billed (if applicable)/CPT, HCPC, DRG or state code and description service

Units

The Number of Units Billed per Line Item

Mod1/Mod2/Mod3/Mod4

Modifiers billed specific to claim line

Billed Amount

Amount Billed

Allowed Amount

Allowed Amount for Claim Line

Disallow Amount

Disallowed Amount or Difference Between Amount Billed and Contract Allowable Amount

COB Amt

Primary Insurance Paid Amount for Claim Line

Co-Pay Applied

Co-Pays apply to certain Covered Services

Net Plan Payable

The amount to be paid/reversed prior to adjustment

Interest

Interest Paid for Late Payment of Claim

Ovp/Refund

Amount received from the provider as a refund, or the overpaid amount requested by the health plan from the provider.

Total Paid/Reversed

The total amount paid/reversed with this remittance advice

FFS/CAP

Defines Type of Payment for Line Item

Line Status

Status of Line (Paid or Denied)

Adj Grp Code

HIPAA compliant Adjustment Type defined at the end of the Remittance Advice

Adj Rsn Code

HIPAA compliant Reason Code defined at the end of the Remittance Advice

Rmk Code

Remit Message Applicable to Line

Message

Explanation of Remit Messages for Denied Lines

Net Plan Payable

The amount to be paid/reversed prior to adjustment

HIPAA compliant Adjustment Type defined at the end of the Remittance Advice