Provider Manual

Molina Healthcare of Washington, Inc.

(Molina Healthcare)

Molina Marketplace Product*
Effective 1/1/2016

***Molina Healthcare's Health Benefit Exchange product is now known as the Molina Marketplace product

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Section 1. Addresses and Phone Numbers

Member Services Department

The Member Services Department handles all telephone and written inquiries regarding Member Claims, benefits, eligibility/identification, selecting or changing Primary Care Providers (PCPs), and Member complaints. Member Services Representatives are available 7:30am to 6:30pm Monday through Friday, excluding State holidays.

Member Services
Address: Molina Healthcare of Washington, Inc. PO Box 4004 Bothell, WA 98041
Phone: (800) 869-7165
TTY: 711

Claims Department

The Claims Department is located at our corporate office in Long Beach, CA. All hard copy (CMS-1500, UB-04) Claims must be submitted by mail to the address listed below. Electronically filed Claims must use Payor ID number - **38336** To verify the status of your Claims, please call our Provider Claims Representatives at the numbers listed below:

Claims
Address: Molina Healthcare of Washington, Inc. PO BOX 22612 Long Beach, CA 90801
Phone: (800) 745-4044

Claims Recovery Department

The Claims Recovery Department manages recovery for Overpayment and incorrect payment of Claims.

Claims Recovery
Refunds
Address: Molina Healthcare of Washington, Inc. PO Box 30717 Los Angeles, CA 90030-0717

Disputes
Address: Molina Healthcare of Washington, Inc. PO Box 2470 Spokane, WA 99210-2470
Phone: (866) 642-8999 Fax: (888) 396-1520

Credentialing Department

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

Credentialing
Address: Molina Healthcare of Washington, Inc. PO Box 2470 Spokane, WA 99210-2470
Phone: (888) 562-5442
Fax: (800) 457-5213 or (800) 457-5203

24-Hour Nurse Advice Line

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

HEALTHLINE (24-Hour Nurse Advice Line)
English Phone: (888) 275-8750 Spanish Phone: (866) 648-3537
TTY: 711 Relay OR (866) 735-2929 (English) (866) 833-4703 (Spanish)

Healthcare Services (UM) Department

The Healthcare Services (formerly UM) Department conducts concurrent review on inpatient cases and processes Prior Authorization requests. The Healthcare Services (HCS) Department also performs Care Management for Members who will benefit from Care Management services.

Healthcare Services Authorizations & Inpatient Census	
Address: Molina Healthcare of Washington, Inc. P.O. Box 4004 Bothell, WA 98041-4004	
Phone:	(800) 869-7175 ext. 751408
Fax:	(800) 767-7188

Health Management and Disease Management Programs

Molina Healthcare's Health Management program can help answer general questions about your health or condition. If you have a general question about your health, please call 1-866-891-2320.

Health Management	
Phone:	1 (866) 891-2320
Fax:	1 (800) 642-3691

Molina Healthcare's Disease Management

Disease Management offers additional support to members by providing a customized approach to education, coaching and care planning to members with the following chronic conditions:

- Asthma
- Prediabetes and Diabetes
- Coronary Artery Disease (CAD)
- Chronic Obstructive Pulmonary Disorder (COPD)
- Congestive Heart Failure (CHF)
- Hypertension
- Obesity

More specifically, Health Managers, who are trained Registered Nurses, help members by:

- Educating members about their disease condition(s)
- Monitoring and managing their health conditions
- Encouraging and supporting communication with their provider(s)
- Providing and referring to helpful resources
- Supporting healthy lifestyle changes

Behavioral Health

Molina Healthcare of Washington, Inc. manages all components of our covered services for behavioral health. For Member behavioral health needs, please contact us directly at:

Behavioral Health
Address: Molina Healthcare of Washington, Inc. P.O. Box 4004 Bothell, WA 98041-4004
(24) Hours per day, (365) day per year:
English Phone: (888) 275-8750 Spanish Phone: (866) 648-3537
TTY: (866) 735-2929 (English) (866) 833-4703 (Spanish)

Pharmacy Department

Molina Healthcare's drug formulary requires prior Authorization for certain medications. The Pharmacy Department can answer questions regarding the formulary and/or drug prior Authorization requests. The Molina Healthcare formulary is available at www.ePocrates.com or www.molinahealthcare.com.

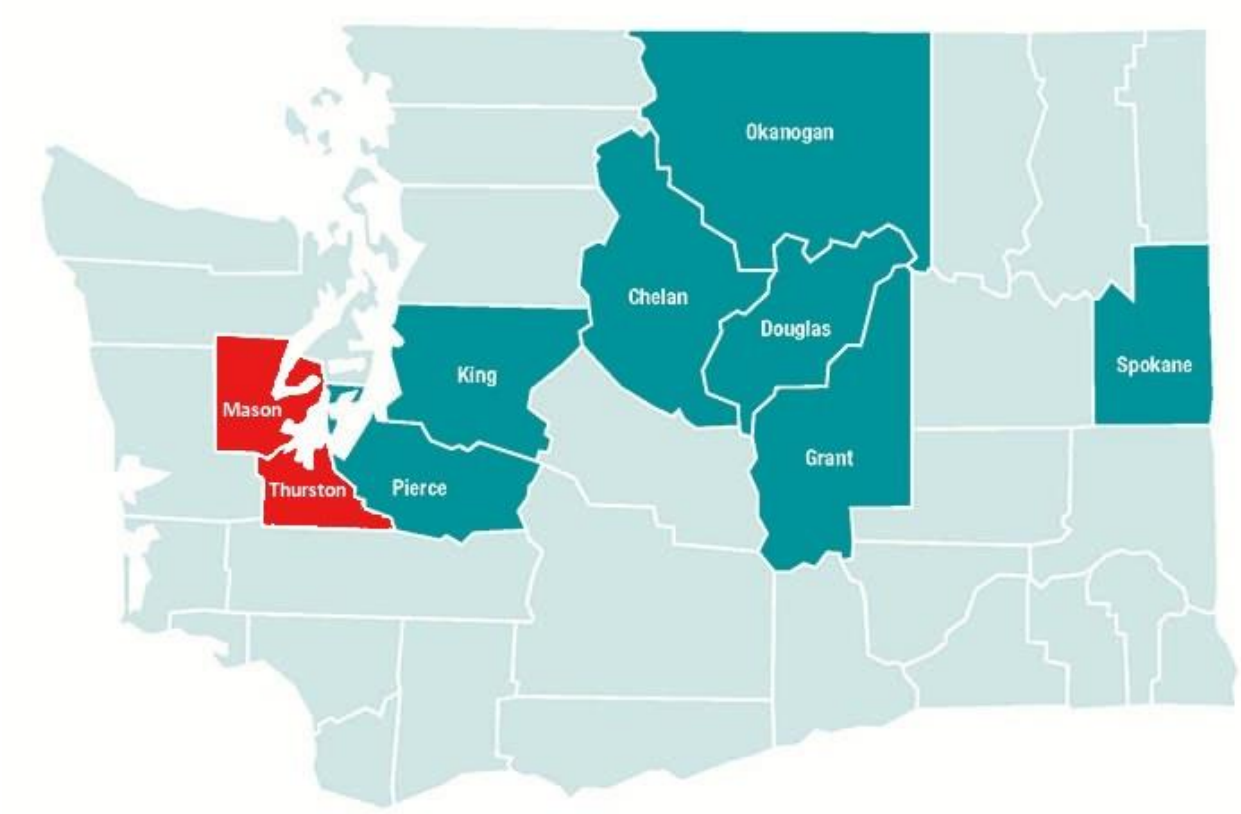
Pharmacy Authorizations	
Phone:	(800) 213-5525
Fax:	(800) 869-7791

Provider Services Department

The Provider Services Department handles telephone and written inquiries from Providers regarding address and Tax-ID changes, Provider denied Claims review, and training. The department has Provider Services Representatives who serve all of Molina Healthcare of Washington's Provider network.

Provider Services	
Address:	Molina Healthcare of Washington, Inc. PO Box 4004 Bothell, WA 98041-4004
Phone:	(800) 869-7175
Fax:	(877) 814-0342

Molina Healthcare of Washington, Inc. Service Area



Section 2. Eligibility, Enrollment, Disenrollment & Grace Period

Enrollment

Enrollment in Molina Marketplace

The Molina Marketplace is the program which implements the Health Insurance Marketplace as part of the Affordable Care Act. It is administered by the Washington Health Benefit Exchange.

To enroll with Molina Healthcare, the Member, his/her representative, or his/her responsible parent or guardian must follow enrollment process established by the Washington Health Benefit Exchange. The Washington Health Benefit Exchange will enroll all eligible Members with the health plan of their choice.

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

Effective Date of Enrollment

Coverage shall begin as designated by the Washington Health Benefit Exchange on the first day of a calendar month. If the enrollment application process is completed by the 23rd of the month, the coverage will be effective on the first day of the next month. If enrollment is completed after the 23rd of the month, coverage will be effective on the first day of the second month following enrollment.

Newborn Enrollment

When a Molina Healthcare Marketplace Subscriber or their Spouse gives birth, the newborn is automatically covered under the Subscriber's policy with Molina Healthcare for the first 31 days of life. In order for the newborn to continue with Molina Healthcare coverage past this time, the infant must be enrolled through the Marketplace Exchange with Molina Healthcare on or before 60 days from the date of birth.

Inpatient at time of Enrollment

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

Eligibility Verification

Health Insurance Marketplace Programs

Payment for services rendered is based on enrollment status and coverage selected. The contractual agreement between Providers and Molina Healthcare places the responsibility for eligibility verification on the Provider of services.

Eligibility Listing for Molina Healthcare Marketplace Programs Providers who contract with Molina Healthcare may verify a Member's eligibility for specific services and/or confirm PCP assignment by checking the following:

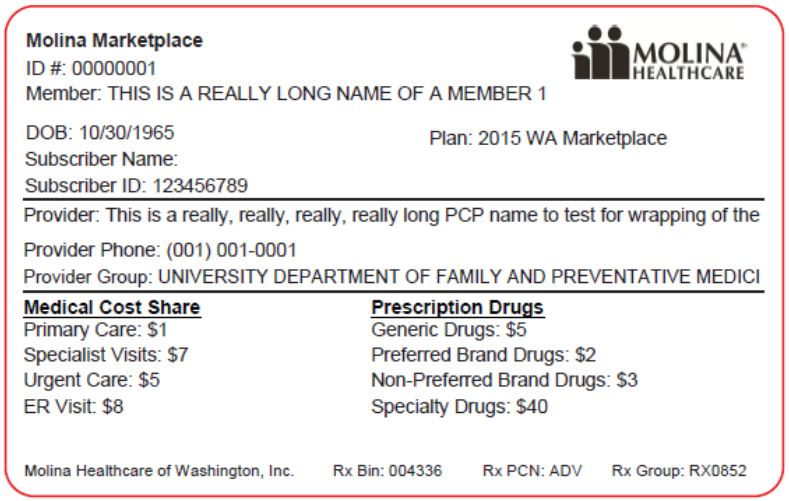
Molina Healthcare Member Services at (800) 869-7165,

Molina Healthcare, Inc.Web Portal https://provider.molinahealthcare.com.

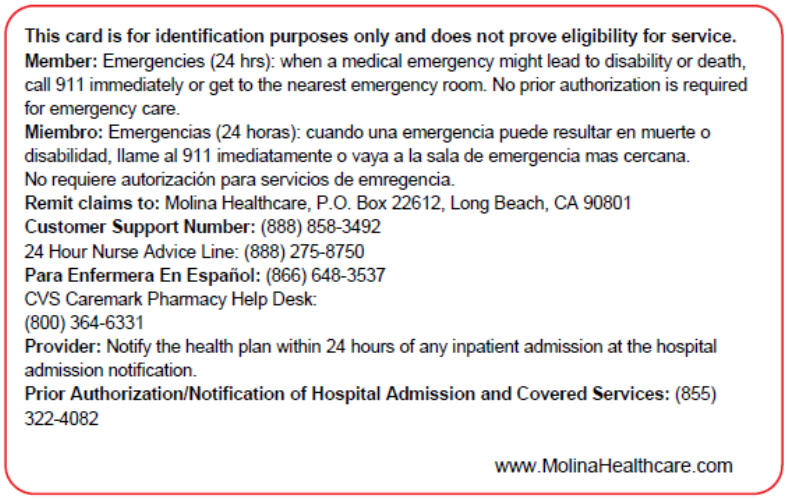
Possession of a Marketplace ID Card does not mean a recipient is eligible for Marketplace services. A Provider should verify a recipient's eligibility each time the recipient presents to their office for services. The verification sources can be used to verify a recipient's enrollment in a Molina Healthcare Marketplace plan.

Molina Healthcare of Washington Sample Member ID card:

Front of card:



Back of card:



Members are reminded in their Member Handbooks to carry ID cards with them when requesting medical or pharmacy services. It is the Provider's responsibility to ensure Molina Healthcare Members are eligible for benefits and to verify PCP assignment, prior to rendering services. Unless an Emergency Medical Condition exists, Providers may refuse service if the Member cannot produce the proper identification and eligibility cards.

Disenrollment

Voluntary Disenrollment

Members have the right to terminate coverage for any reason at any time. However, beyond the open-enrollment period, if a Member elects to terminate coverage with Molina Healthcare Marketplace, they are not eligible to re-enroll with another health plan until the following year's open-enrollment period unless there is a life event, and they qualify for a Special Enrollment Period (SEP) or if they are American Indian or Alaska Native. Members may discontinue Molina coverage by contacting the Marketplace Exchange.

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

Involuntary Disenrollment

Under very limited conditions and in accordance with the Marketplace Exchange guidelines, Members may be involuntarily disenrolled from a Molina Healthcare Marketplace program. With proper written documentation and approval by the Washington Health Benefit Exchange or its Agent; the following are acceptable reasons for which Molina Healthcare may submit Involuntary Disenrollment requests to the Washington Health Benefit Exchange:

- Delinquency of payment, past defined grace period(s)
- Member has moved out of the Service Area
- Member death
- Member's utilization of services is fraudulent
- Member ages out of coverage (e.g., dependent child age >26

PCP Assignment

Molina Healthcare will offer each Member a choice of Primary Care Providers (PCPs). After making a choice, each Member will have a single PCP. Molina Healthcare will assign a PCP to those Members who did not choose a PCP at the time of Molina Healthcare selection. Molina Healthcare will take into consideration the Member's last PCP (if the PCP is known and available in Molina Healthcare's contracted network), closest PCP to the Member's home address, ZIP code location, keeping Children/Adolescents within the same family together, age (adults versus Children/Adolescents) and gender (OB/GYN).. Molina Healthcare will allow pregnant Members to choose the Health Plan's obstetricians as their PCPs to the extent that the obstetrician is willing to participate as a PCP.

PCP Changes

Members can change their PCP at any time. All changes completed the end of the month will be in effect on the first day of the following calendar month.

Grace Period

Definitions:

APTC Member: A Member who receives advanced premium tax credits (premium subsidy), which helps to offset the cost of monthly premiums for the Member.

Non-APTC Member: A Member who is not receiving any advanced premium tax credits, and is therefore solely responsible for the payment of the full monthly premium amount.

Member: An individual, including any dependents, enrolled in Molina Marketplace. This term includes both APTC Members and Non-APTC Members.

Summary:

The Affordable Care Act mandates that all qualified health plans offering insurance through the Health Insurance Marketplace provide a grace period of three (3) consecutive months to APTC Members who fail to pay their monthly premium by the due date. Molina Marketplace also offers a grace period in accordance with State Law to Non-APTC Members who fail to pay their monthly premium by the due date. To qualify for a grace period, the Member must have paid at least one full month's premium within the benefit year. The grace period begins on the first day of the first month for which the Member's premium has not been paid. The grace period is not a "rolling" period. Once the Member enters the grace period, they have until the end of that period to resolve the entire outstanding premium balance; partial payment will not extend the grace period.

Grace Period Timing:

Non-APTC Members:

Non-ATPC Members are granted a a thirty day grace period, during which they may be able to access some or all services covered under their benefit plan. If the *full past-due premium* is not paid by the end of the grace period, the Non-APTC Member will be terminated effective the last day of the month prior to the beginning of the grace period.

APTC Members:

APTC Members are granted a three (3) month grace period. During the first month of the grace period Claims and authorizations will continue to be processed, including Pharmacy Claims. Services, authorization requests and Claims may be denied or have certain restrictions during the second and third months of the grace period. If the APTC Member's *full past-due premium* is not paid by the end of the third month of the grace period, the APTC Member will be retroactively terminated to the last day of the first month of the grace period.

Service Alerts:

When a Member is in the grace period, Molina Healthcare, Inc. ("Molina") will include a service alert on the Web Portal, interactive voice response (IVR) and in the call centers. This alert will provide detailed information about the Member's grace period status, including which month of the grace period that the Member is in the grace period (first month vs. second and third) as well as information about how authorizations and Claims will be processed during this time. Providers should verify both the eligibility status AND any service alerts when checking a Member's eligibility. For additional information about how authorizations and Claims will be processed during this time, please refer to the Member Evidence of Coverage, or contact Molina's Member Services Department at (800) 869-7165.

Notification:

All Members will be notified upon entering the grace period. Additionally, when an APTC Member enters the grace period, Molina will provide notification to Providers who submit Claims for services rendered to the APTC Member during the grace period. This notification will advise Providers that payment for services rendered during the second and third months of the grace period may be denied if the premium is not *paid in full* prior to the expiration of the third month of the grace period.

Prior Authorizations:

APTC Members:

Authorization requests received during the first month of an APTC Member's grace period will be processed according to Medical Necessity standards. Authorizations received during the second and third month of the APTC Member's grace period will be denied, due to the suspension of coverage. If the APTC Member pays the full premium payment prior to the expiration of the grace period, Providers may then seek authorization for services. If the APTC Member did not receive services during the second or third month of the grace period because the prior authorization was denied, the Provider must submit a new authorization request for those services. If the APTC Member received services during the second or third month of the grace period without a prior authorization, the Provider may request a retro-authorization for those services already rendered. All authorization requests will be reviewed based on Medical Necessity.

Non-APTC Members:

Authorization requests received during a Non-APTC Member's grace period will be processed according to Medical Necessity standards.

Claims Processing:

APTC Members:

First Month of Grace Period: Clean Claims received for services rendered during the first month of a grace period will be processed using Molina's standard processes and in accordance with State and Federal statutes and regulations and within established turn-around-times.

Second/Third Month of Grace Period: Clean Claims received for services rendered during the second and third months of an APTC Member's grace period will be pended until the premium is paid in full. In the event that the APTC Member is terminated for non-payment of the *full premium* prior to the end of the grace period, Molina will deny Claims for services rendered in the second and third months of the grace period. Pharmacy Claims will be processed based on program drug utilization review and formulary edits; the APTC Member will be charged 100% of the discounted cost for prescriptions filled during the second and third months of the grace period.

Non-APTC Members:

Clean Claims received for services rendered during the grace period will be processed using Molina's standard processes and in accordance with State and Federal statutes and regulations and within established turn-around-times.

Section 3. Member Rights and Responsibilities

This section explains the rights and responsibilities of Molina Healthcare Members as written in the Molina Evidence of Coverage. Washington Law requires that health care Providers or health care facilities recognize Member rights while they are receiving medical care and that Members respect the health care Provider's or health care facility's right to expect certain behavior on the part of patients.

Below are the Member Rights and Responsibilities:

Molina Healthcare Member Rights & Responsibilities Statement

YOUR RIGHTS

- **You have the right to:**
- **Be treated with respect and recognition of Your dignity by everyone who works with Molina.**
- **Get information about Molina, Our providers, Our doctors, Our services and Members' rights and responsibilities.**
- **Choose your "main" doctor from Molina's list of Participating Providers (This doctor is called Your Primary Care Doctor or Personal Doctor).**
- **Be informed about your health. If you have an illness, You have the right to be informed of all treatment options regardless of cost or benefit coverage. You have the right to have all your questions about your health answered.**
- **Help make decisions about your health care. You have the right to refuse medical treatment.**
- **You have a right to Privacy. We keep your medical records private.***
- **See Your medical record. You also have the right to get a copy of and correct Your medical record where legally allowed.***
- **Complain about Molina or Your care. You can call, fax, e-mail or write to Molina's Customer Support Center.**
- **Appeal Molina's decisions. You have the right to have someone speak for You during Your grievance.**
- **Disenroll from Molina (leave the Molina Policy).**
- **Ask for a second opinion about your health condition.**
- **Ask for someone outside Molina to look into therapies that are Experimental or Investigational.**
- **Decide in advance how you want to be cared for in case You have a life-threatening illness or injury.**

- **Get interpreter services on a 24-hour basis at no cost to help You talk with Your doctor or with Us if You prefer to speak a language other than English.**
- **Get information about Molina, Your providers, or your health in the language You prefer.**
- **Ask for and get materials in other formats such as, larger size print, audio and Braille upon request and in a timely fashion appropriate for the format being requested and in accordance with state laws.**
- **Free Information on medical necessity criteria due to adverse benefit determinations.**
- **Get a copy of Molina's list of approved drugs (Drug Formulary) on request.**
- **Submit a grievance if you do not get Medically Necessary medications after an Emergency visit at one of Molina's contracted hospitals.**
- **Not to be treated poorly by Molina or Your doctors for acting on any of these rights.**
- **Make recommendations regarding Molina's Member rights and responsibilities policies.**
- **Be free from controls or isolation used to pressure, punish, or seek revenge.**
- **File a grievance or complaint if you believe your linguistic needs were not met by Molina.**

Your Responsibilities

You have the responsibility to:

- **Learn and ask questions about your health benefits. If you have a question about your benefits, call toll-free at 1 (888)858-3492.**
- **Give information to your doctor, provider, or Molina Healthcare that is needed to care for you.**
- **Be active in decisions about your health care.**
- **Follow the care plans for you that you have agreed on with your doctor(s).**
- **Build and keep a strong patient-doctor relationship. Cooperate with Your doctor and staff. Keep appointments and be on time. If you are going to be late or cannot keep Your appointment, call Your doctor's office.**
- **Give Your Molina card when getting medical care. Do not give your card to others. Let Molina know about any fraud or wrongdoing.**
- **Understand your health problems and participate in developing mutually agreed-upon treatment goals, as you are able.**

Second Opinions

If a Member does not agree with their Provider's plan of care, they have the right to request a second opinion from another Provider. Members should call Member Services to find out how to get a second opinion. Second opinions may require Prior Authorization.

Section 4. Benefits and Covered Services

Molina Healthcare covers the services described in the Summary of Benefits and Evidence of Coverage (EOC) documentation for each Molina Marketplace plan type. If there are questions as to whether a service is covered or requires prior authorization, please contact Molina Healthcare at (800) 869-7175 Monday through Friday 7:30am to 6:30pm excluding State holidays.

Member Cost Sharing

Cost Sharing is the Deductible, Copayment, or Coinsurance that Members must pay for Covered Services provided under their Molina Marketplace plan. The Cost Sharing amount Members will be required to pay for each type of Covered Service is summarized on the Member's ID card. Additional detail regarding cost sharing listed in the Schedule of Benefits located in the EOC. Cost Sharing applies to all Covered Services except for preventive services included in the Essential Health Benefits (as required by the Affordable Care Act). Cost Sharing towards Essential Health Benefits may be reduced or eliminated for certain eligible Members, as determined by Marketplace's rules.

It is the Provider's responsibility to collect the copayment and other Member Cost Share from the Member to receive full reimbursement for a service. The amount of the copayment and other Cost Sharing will be deducted from the Molina Healthcare payment for all Claims involving Cost Sharing.

Services Covered by Molina Healthcare Links to Summaries of Benefits

The following web link provides access to the Summary of Benefits guides for the 2016 Molina Marketplace products offered in Washington.

http://www.molinahealthcare.com/members/wa/en-US/hp/marketplace/plans/Pages/plans.aspx

Links to Summary of Benefits

Detail information about benefits and services can be found in the 2016 Summary of Benefits booklets made available to Molina Marketplace Members.

The following web link provides access to the Summary of Benefits booklets for the 2016 Molina Marketplace products offered in Washington.

http://www.molinahealthcare.com/members/wa/en-US/PDF/marketplace/summary-of-benefits-choice-gold-2016.pdf

http://www.molinahealthcare.com/members/wa/en-US/PDF/marketplace/summary-of-benefits-choice-silver-250-2016.pdf
http://www.molinahealthcare.com/members/wa/en-US/PDF/marketplace/summary-of-benefits-choice-silver-250-aian-2016.pdf
http://www.molinahealthcare.com/members/wa/en-US/PDF/marketplace/summary-of-benefits-choice-silver-200-2016.pdf
http://www.molinahealthcare.com/members/wa/en-US/PDF/marketplace/summary-of-benefits-choice-silver-150-2016.pdf
http://www.molinahealthcare.com/members/wa/en-US/PDF/marketplace/summary-of-benefits-choice-silver-100-2016.pdf
http://www.molinahealthcare.com/members/wa/en-US/PDF/marketplace/summary-of-benefits-choice-bronze-2016.pdf
http://www.molinahealthcare.com/members/wa/en-US/PDF/marketplace/summary-of-benefits-choice-bronze-aian-2016.pdf
http://www.molinahealthcare.com/members/wa/en-US/PDF/marketplace/summary-of-benefits-standard-gold-2016.pdf
http://www.molinahealthcare.com/members/wa/en-US/PDF/marketplace/summary-of-benefits-standard-silver-250-2016.pdf
http://www.molinahealthcare.com/members/wa/en-US/PDF/marketplace/summary-of-benefits-standard-silver-250-aian-2016.pdf
http://www.molinahealthcare.com/members/wa/en-US/PDF/marketplace/summary-of-benefits-standard-silver-200-2016.pdf
http://www.molinahealthcare.com/members/wa/en-US/PDF/marketplace/summary-of-benefits-standard-silver-150-2016.pdf
http://www.molinahealthcare.com/members/wa/en-US/PDF/marketplace/summary-of-benefits-standard-silver-100-2016.pdf

Obtaining Access to Certain Covered Services

Prescription drugs

Prescription drugs are covered by Molina Healthcare, via our pharmacy vendor, CVS Caremark. A list of in-network pharmacies is available on the www.molinaheathcare.com website, or by contacting Molina Healthcare. Members must use their Molina Healthcare ID card to get prescriptions filled. Additional information regarding the pharmacy benefits, and its limitations, is available by contacting Molina Healthcare at (800) 213-5525.

Non-Formulary Drug Exception Request Process

There are two types of requests for clinically appropriate drugs that are not covered under the Member's Marketplace plan type. :

- "Expedited Exception Request" for urgent circumstances that may seriously jeopardize life, health or ability to regain maximum function, or for undergoing current treatment using non-Drug Formulary drugs.
- "Standard Exception Request"
- The Member and/or Member's Representative and the prescribing Provider will be notified of Molina Healthcare's decision no later than:
- 24 hours following receipt of request for Expedited Exception Request
- 72 hours following receipt of request for Standard Exception Request
- If the initial request is denied, An external review may be requested. The Member and/or Member's Representative and the prescribing Provider will be notified of the external review decision no later than:
- 24 hours following receipt of the request for external review of the Expedited Exception Request

- 72 hours following receipt of the request for external review of the Standard Exception Request

Mail Order Availability of Drug Formulary Prescription Drugs

Molina offers Members who subscribe to a Molina CHOICE plan a mail order option for prescription drugs on Our Drug Formulary. This option applies only to prescription drug tiers 1, 2, 3 and 5. These prescription drugs can be mailed to Members within 10 days from order request and approval. Cost Sharing for a 90-day supply by mail order is two times the Cost Sharing listed on the Benefits and Coverage Guide for a standard 30-day supply.

Members may request mail order service in the following ways:

- Members can order online. Visit [www.molinahealthcare.com/marketplace] and select the mail order option. Then follow the prompts.
- Members can call the FastStart® toll-free number at 1 (800) 875-0867. Members will be required to provide: Molina Marketplace Member number (found on the card), prescription (medication) name(s), prescribing Provider's name and phone number, and Member's mailing address
- Members can mail a mail-order request form. Visit [www.molinahealthcare.com/marketplace] and select the mail order form option. Members must complete and mail the form to the address on the form along with payment.
- Providers can call, fax or electronically prescribe using the the toll-free FastStart® physician number [1 (800) 378-5697. To speed up the process, Providers will need the Molina Marketplace Member number (found on the ID card), Member date of birth, and Member mailing address.

Injectable and Infusion Services

Many self-administered and office-administered injectable products require Prior Authorization (PA). In some cases they will be made available through a vendor, designated by Molina Healthcare. More information about our Prior Authorization process, including a PA request form, is available in Section 7 of this manual.

Family planning services related to the injection or insertion of a contraceptive drug or device are covered at no cost.

Access to Mental Health and Substance Abuse Services

Members in need of Mental Health or Substance Abuse Services can be referred by their PCP for services or Members can self-refer by calling Molina Healthcare of Washington Behavioral Health Department at (888) 275-8750. Molina Healthcare Nurse Advice Line is available 24 hours a day, 7 days a week for mental health or substance abuse needs. The services Members receive will be confidential. Additional detail regarding Covered Services and any limitations can be obtained in the EOCs linked above, or by contacting Molina Healthcare. All outpatient professional mental health and substance abuse services will be charged the primary care copay equivalent.

Emergency Mental Health or Substance Abuse Services

Members are directed to call “911” or go to the nearest emergency room if they need Emergency mental health or substance abuse services. Examples of Emergency mental health or substance abuse problems are:

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

Out of Area Emergencies

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

- Go to the nearest hospital or facility
- Call the number on ID card
- Call Member’s PCP and follow-up within (24) to (48) hours

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

Obtaining Mental Health or Substance Abuse Services

Please call the appropriate Member Services or Provider Services number or the Behavioral Health Department to find a mental health or substance abuse Provider.

Emergency Transportation

When a Member’s condition is life-threatening and requires use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility, emergency transportation is thus required. Emergency transportation includes, but is not limited to, ambulance, air or boat transports.

Non-Emergency Transportation

Molina Healthcare provides coverage for non-emergency transportation for certain Molina Marketplace Standard plan types to Members who meet certain requirements. Non-Emergency Transportation is covered at no charge. **To find out if this is a covered service for your patient, please contact Molina Healthcare at** (800) 869-7165**.**

Non-Emergency Medical Transportation

For Molina Marketplace Standard plan Members who have non-emergency medical transportation as a covered service, Molina Healthcare covers transportation to medical facilities when the Member’s medical and physical condition does not allow them to take regular means of public or private transportation (car, bus, air, etc.). This requires a written prescription from the Member’s doctor. Examples of non-Emergency medical transportation include, but are not limited to, litter vans and wheelchair accessible vans. Members must have Prior Authorization from Molina Healthcare for ground and air ambulance services before the services are given. Prior Authorization is not required for vans, taxi, etc. Additional information regarding the availability of this benefit is available by contacting Member Service at (800) 869-7165.

Non-Emergency Non-Medical Transportation

Non-Emergency non-medical transportation is available to Members who have non-emergency transportation as a covered service and are recovering from serious injury or medical procedure that prevents them from driving to a medical appointment. The Member must have no other form of transportation available. Prior Authorization is required to access these services. A Physician (PCP or Specialist) must confirm that a Member requires non-Emergency non-medical transportation to and from an appointment on a specified date. Additional information regarding the availability of this benefit is available by contacting Member Services at (800) 869-7165

Non-Emergency non-medical transportation for Members to medical services can be supplied by a passenger car, taxi cabs, or other forms of public/private transportation. Members are instructed to call the transportation vendor at least two to three working days before the appointment to arrange this transportation.

Preventive Care

Preventive Care Guidelines are located on the Molina Healthcare Website. Please use the link below to access the most current guidelines:

http://www.molinahealthcare.com/providers/common/marketplace/resource/Pages/hlthguide.aspx

We need your help conducting these regular exams in order to meet the targeted State and Federal standards. If you have questions or suggestions related to well child care, please call our Health Education line at (800) 423-9899.

Emergency Services

Emergency Services means: Inpatient and outpatient contracted services furnished by a provider qualified to furnish the services needed to evaluate or stabilize an emergency medical condition.

Emergent and urgent care Services are covered by Molina Healthcare without an authorization. This includes non-contracted Providers inside or outside of Molina Healthcare's service area.

(24) Hour Nurse Advice Line

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

HEALTHLINE **(24-Hour Nurse Advice Line)**
English Phone: (888) 275-8750 Spanish Phone: (866) 648-3537
TTY: 711 Relay Or

(866) 735-2929 (English) (866) 833-4703 (Spanish)

Molina Healthcare is committed to helping our Members:

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

These registered nurses do not diagnose. They assess symptoms and guide the patient to the most appropriate level of care following specially designed algorithms unique to the Nurse Advice Line. The Nurse Advice Line may refer back to the PCP, a specialist, 911 or the ER. By educating patients, it reduces costs and over utilization on the health care system.

Health Management Programs

Molina Healthcare of Washington Health Management programs provide patient education information to Members and facilitate Provider access to these chronic disease programs and services. Health Management staff; Registered Nurse, Registered Dietitian, Social Worker, and or Health Educator are available telephonically to share information about Molina Programs. They will assist Members with preventative education and management of their conditions. He/she will collaborate with the Member and Provider relating to specific needs identified for best practices. Molina requests that you as a Provider also help us identify Members who may benefit from these programs. Members can request to be enrolled or dis-enrolled in these programs. These include programs, such as:

- Asthma
- Diabetes

For more info about our programs, please call:

- Member Services Department at (800) 869-7165
- (English) TTY at: 711
- Visit www.molinahealthcare.com

Program Eligibility Criteria and Referral Source

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

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

- Pharmacy Claims data for all classifications of medications;

- Encounter Data or paid Claim with a relevant CMS accepted diagnosis or procedure code;
- Member Services welcome calls made by staff to new Member households and incoming Member calls have the potential to identify eligible program participants. Eligible Members are referred to the program registry;
- Provider referral;
- Nurse Advice referral;
- Medical Case Management or Utilization Management; and
- Member self-referral due to general plan promotion of program through Member newsletter, the Nurse Advice Line or other Member communication

Provider Participation

Contracted Providers are automatically notified whenever their patients are enrolled in a health management program. Provider resources and services may include:

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

Additional information on health management programs is available from your local Molina HCS Department toll free at (800) 869-7165.

Motherhood Matters [SM] Program

Motherhood Matters [SM] Pregnancy Program encompasses clinical case management, Member outreach, and Member/Provider communication and education. The Prenatal Case Management staff works closely with the Provider community in identification, assessment, and implementation of appropriate intervention(s) for every Member participating in the program.

We care about the health of our pregnant Members and their babies. Molina's pregnancy program will make sure Member and baby get the needed care during the pregnancy. You can speak with trained Nurses and Care Managers. They can give your office/Member the support needed and answer questions you may have. You will be mailed a workbook and other resources which are also available to the Member. The Member will also learn ways to stay healthy after child birth.

Special care is given to those who have a high-risk pregnancy. If a Member is identified as having high risk pregnancy, the Member will be assigned a telephonic high risk OB RN Case Manager throughout her pregnancy as well as postpartum follow up. If Member is identified as high risk she may also be a candidate for the 17P program to help prevent preterm labor. The RN can coordinate this with the Provider, the plan, and the Member.

It is the Member's choice to be in the program. They can choose to be removed from the program at any time. Molina Healthcare is requesting your office to complete the Pregnancy

Notification Form (refer to molinahealthcare.com website for form) and return it to us as soon as pregnancy is confirmed.

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

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

Weight Management

Weight Watchers®

The Weight Watchers® program is available to members 18 years and older who qualify. For information about this program, call our Corporate Education department at 866-472-9483.

Our Corporate Weight Management Program Includes:

Given the diversity of Molina Healthcare's membership, a health management program created around weight management is designed to improve the quality of life among our Members and enhance clinical outcomes in the future. Helping our Members reduce unhealthy behaviors will improve their ability to manage pre-existing illnesses or chronic conditions.

Molina's Weight Management program is comprised of telephonic outreach by a multi-disciplinary team of Health Managers, Health Educators, and Providers to support the weight management needs of the Member.

Molina's Health education program encompasses one-on-one telephonic education and coaching. The Health Education staff work closely with the Member's Provider to implement appropriate intervention(s) for Members participating in the program. The program consists of multi-departmental coordination of services for participating Members and uses various approved health education/information resources such as: Centers For Disease Control, National Institute of Health, and Clinical Care Advance system for health information and assessment tools. Health education resources are intended to provide both general telephonic health education and targeted information based on the needs of the individual.

Goals of Weight Management Program:

The goals of the Weight Management program are to:

1. Counsel on the health benefits of weight loss.
   - One-on-one telephonic counseling
   - BMI Identification
   - Provider and community resource referral
2. Promote Healthy Eating Habits
   - Teach basic nutrition concepts
     - Healthy Plate Method
     - Meal spacing and portion control
     - Tips on grocery shopping
     - Label reading
     - Healthy cooking method tips
     - Eating out tips
3. Teach Behavior Modification techniques
   - Promote healthy lifestyle changes
   - Monitor eating behavior
   - Rewarding oneself for healthy changes and progress
4. Encourage Regular Exercise
   - Advise Member to always talk to their Provider before starting any exercise program
   - Promote increased physical activity that is realistic and achievable.
     - Walking
     - Dancing
     - Sit and Be Fit program on PBS
   - Actively involve Providers, Members, families, and other care Providers in the planning, implementation, and evaluation of care.
   - Monitor program effectiveness through the evaluation of outcomes.

Program Benefits:

- Access to a Health Educator for telephonic counseling on weight management
- Community class referrals in participating areas and self-help education materials if available
- Referral to Online Programs; www.sparkpeople.com, www.sparkteens.com, www.choosemyplate.gov

To find out more information about the health management programs, please call Member Services Department at (800) 869-7165.

Smoking Cessation

Smoking can negatively impact your health and the health of those around you. The Quit-4-Life program and Molina's smoking cessation program uses a combination of telephonic outreach by a multi-disciplinary team of Care Managers, Provider, and pharmacy engagement to support the smoking cessation needs of the Member. The team works closely with contracted Providers and pharmacist to identify appropriate pharmacologic cessation aids when applicable.

If you are interested in quitting, please call the Quit-4-Life program (1-866-784-8454) to speak with a coach today. For information about Molina's Smoking Cessation program call 1 (866)-472-9483.

The goals of the Molina Smoking Cessation program:

1. Deal with the three aspects of smoking - Addiction, Habit, and Psychological Dependency
   - Use smoking cessation aids
   - Learning to Cope
   - Change beliefs
2. Identify Stress Management & Coping Techniques
   - Practice relaxation & visualization techniques
   - Create support network
3. Identify Pharmacologic Cessation Aids
4. Prepare for Quit Day/Maintaining the Quit
   - Devise relapse prevention strategies
   - Review the Anticipate-Plan-Rehearse model
5. Actively involve Providers, Members, families, and other care Providers in the planning, provision, and evaluation of care.
6. Improve the quality of information collection and statistical analysis; in order to assess the effectiveness of the program and to project future needs.
7. Monitor program effectiveness through the evaluation of outcomes.

To find out more information about the health management programs, please call Member Services Department at (800) 869-7165.

Section 5. Provider Responsibilities

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

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

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

Access to Care Standards

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

For additional information about how Molina Healthcare audits access to care, please refer to the Quality Improvement section of this manual.

Type of Care	Appointment Wait Time
Preventive Care Appointment	Within 30 calendar days of request
Routine Primary Care	Within 10 calendar days of request
Urgent Care	Within 48 hours
Emergency Care	Available by phone 24 hours/seven days
After-Hours Care	Available by phone 24 hours/seven days
Office Waiting Time	Should not exceed 30 minutes

Relocations and Additional Sites

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

Site and Medical Record-Keeping Practice Reviews

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

Member Information and Marketing

Any written informational and marketing materials directed at Molina Healthcare Members must be written at or below the fifth (5^{th}) grade reading level, and have prior written consent from Molina Healthcare and the appropriate government agencies. Please contact your Provider Services Representative for information and review of proposed materials. Neither Molina Healthcare, nor any contracted Providers nor medical groups/IPA may:

- Distribute to its Members informational or marketing materials that contain false or misleading information
- Distribute to its Members marketing materials selectively within the Service Area
- Directly or indirectly conduct door-to-door, telephonic, or other cold-call marketing for Member enrollment

Electronic Solutions Participation

Molina Healthcare encourages Providers to utilize electronic solutions and tools whenever possible. Molina Healthcare offers a number of electronic solutions to our Providers. These tools are intended to improve Provider access to information related to Molina Healthcare Members, and increase the level of services and support received by providing faster turn-around-times and creating efficiencies.

Electronic Tools/Solutions available to Providers include:

- Provider Web Portal
- Electronic Claims Submission Options
- Electronic Payment (Electronic Funds Transfer) with Electronic Remittance Advice (ERA)

Provider Web-Portal

Molina Healthcare Providers may register on the Web Portal to verify Member eligibility and benefits, submit or search for service request/authorizations, submit Claims or view Claims status and view other information that is helpful.

Enhanced Security – Online access is more secure than phone or fax so Providers are encouraged to communicate with Molina Healthcare online. The Provider registration process includes a how-to video guides Providers on the Web-Portal registration process. Providers may add additional users to their accounts. The level of access to information can be better controlled online, further improving information security.

Claims Status and Submissions– In the Web Portal, Providers can submit Claims, view Claim status updates, and receive status change notifications. Claims Information is updated daily so Providers will know sooner if a Claim is paid or denied. Messaging capabilities will automatically notify Providers of Claims and service request/authorization status changes. Providers can also submit Claims in batch, create Claims templates, submit corrected Claims and void Claim submissions.

Service Request/Authorization Enhancements – Providers are able to apply templates to requests that they use frequently, to copy information from previous requests, and to attach documentation and clinical notes, reducing the time it takes to prepare and submit requests. Providers are also able to view service requests/authorizations for their patients/Molina Healthcare Members and will receive notifications when they create a service request/ authorization to determine if a patient/Molina Healthcare Member previously received the service.

Member Eligibility – Providers can access their Member eligibility details – with a Quick View bar that summarizes the Member's eligibility at a glance. Additional Member details include Member HEDIS missed services, benefit summary of covered services and access to Member handbooks.

Member Roster - The Web Portal offers a flexible Member Roster tool to help make Member management easier for Providers. The feature provides the ability to view an up-to-date Member list and customize Member searches with built-in filters. Providers can view various

statuses for multiple Members – such as new Members, inpatients that are or will be in a hospital, and if any Member has missing services through HEDIS alerts. This feature also acts as a hub to access other applications within the Web Portal such as Claims, Member Eligibility, and Service Request/Authorizations.

HEDIS Scorecard - The Healthcare Effectiveness Data and Information Set (HEDIS) Scorecard measures the performance of care and needed services conducted by a Provider. The HEDIS data is specifically measured so that the scores can be compared amongst various health plans. This feature emphasizes the quality aspect to our Providers and Members. The HEDIS Scorecard also allows HEDIS submissions to be electronic and automated, making delivery of documentation to the Molina HEDIS and Quality Department quicker and more efficient.

Electronic Claims Submission

Molina Healthcare encourages Providers to submit Claims electronically. Electronic Claims submission provides significant benefits to the Provider including:

- Reduction in operational costs associated with paper Claims (printing, postage, etc.)
- Ensures HIPAA Compliance
- Increased accuracy of data and efficient information delivery
- Reduction in Claims delays (since errors can be corrected and re-submitted electronically)
- Claims reach Molina Healthcare faster, since there is no mailing time

Molina Healthcare offers the following electronic Claims submission options:

- Submit Claims directly to Molina Healthcare of Washington via the Provider Portal
- Submit Claims to Molina Healthcare via your regular EDI clearinghouse using Payor ID 38336

For more information on EDI Claims submission, see the Claims Section of this Provider Manual.

Electronic Payment

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

Section 6. Medical Management Program

Introduction

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

Medical Necessity Review

In conjunction with regulatory guidance from Federal and State regulations and industry standards, Molina Healthcare only reimburses services provided to its Members that are medically necessary. Molina Healthcare may conduct a Medical Necessity review of all requests for authorization and Claims, within the specified time frame governed by Federal or State Law for all lines of business. This review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively, as long as the review complies with Federal or State regulations and the Molina Healthcare Hospital or Provider Services Agreement.

Clinical Information

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

Prior Authorization

Molina Healthcare requires prior authorization for specified services as long as the requirement complies with Federal or State regulations and the Molina Healthcare Hospital or Provider Services Agreement. The list of services that require prior authorization is available in narrative form, along with a more detailed list by CPT and HCPCS codes. Molina Healthcare prior authorization documents are updated annually and the current documents are posted on the Molina Healthcare website. Molina Healthcare has included at the end of this section of this manual a copy of the current Authorization Request form. If using a different form, the prior authorization request must include the following information:

- Member demographic information (name, date of birth, Molina Healthcare ID number, etc.)
- Provider demographic information (referring Provider and referred to Provider/facility)
- Requested service/procedure, including all appropriate CPT, HCPCS and ICD-9 codes
- Clinical information sufficient to document the Medical Necessity of the requested service

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Federal and State Law) are excluded from the prior authorization requirements.

Molina Healthcare will process any non-urgent requests within five (5) calendar days of the receipt of necessary information, but are allowed up to fourteen (14) calendar days, if additional information is required and requested by the Contractor within five (5) calendar days of the original receipt of the request for services. For all urgent requests, the decision must be made within forty-eight (48) hours of receipt of request.

Providers who request Prior Authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina Healthcare has a full-time Medical Director available to discuss Medical Necessity decisions with the requesting Provider at (855) 322-4082.

Requesting Prior Authorization

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

Fax: The Prior Authorization form can be faxed to Molina Healthcare at: (800) 767-7188. If the request is not on the form provided in this manual, be sure to send to the attention of the Healthcare Services Department. Please indicate on the fax if the request is urgent or non-urgent. **The Definition of expedited/urgent is when the situation where the standard time frame or decision making process (up to 14 days per Molina's process) could seriously jeopardize the life or health of the enrollee, or could jeopardize the enrollee's ability to regain maximum function.** Please include the supporting documentation needed for Molina to make a determination along with the request to facilitate your request being made as expeditiously as possible

Phone: Prior Authorizations can be initiated by contacting Molina's Healthcare Services Department at (855) 322-4082. It may be necessary to submit additional documentation before the authorization can be processed.

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

Molina Healthcare of Washington
Attn: Healthcare Services Dept.
PO Box 4004
Bothell, WA 98041-4004

Hospitals

Emergency Services

Emergency Services means: Inpatient and outpatient contracted services furnished by a provider qualified to furnish the services needed to evaluate or stabilize an emergency medical condition.

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

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

Admissions

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

Inpatient Management

Elective Inpatient Admissions

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

Emergent Inpatient Admissions

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

Concurrent Inpatient Review

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

Inpatient Status Determinations

Molina Healthcare's Care Access and Monitoring (CAM) staff determine if the collected medical records and clinical information for requested services are "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of malformed body Member" by meeting all coverage, coding and Medical Necessity requirements. The following

are the common criteria sets used by CAM staff to make a determination of Medical Necessity (hierarchy listed from top to bottom): State Medicaid Provider Manuals, Health Technology Assessment, Medical Coverage Guidelines (MCG), Interqual, and Official Disability Guidelines.

Readmission Policy

Hospital readmissions within thirty (30) days potentially constitute a quality of care problem. Readmission review is an important part of Molina Healthcare's Quality Improvement Program to ensure that Molina Healthcare Members are receiving hospital care that is compliant with nationally recognized guidelines as well as Federal and State regulations.

Molina Healthcare will review all hospital subsequent admissions that occur within the time frames allowed by Federal and State Law of the previous discharge for all Claims. Reimbursement for readmissions will be limited to the payment for the first admission and the second payment will be denied unless it meets one of the exceptions noted below, violates State and/or Federal Law or violates the terms of the Hospital or Provider Services Agreement between the Hospital and Molina. If the readmission occurs at a different facility the second admission will be reimbursed and the payment to the first facility will not be eligible for payment due to readmission unless the case meets one of the exception noted below, violates State and/or Federal Law or violates the terms of the Hospital or Provider Services Agreement between the Hospital and Molina.

Exceptions

1. The readmission is determined to be due to an unrelated condition from the first inpatient admission AND there is no evidence that premature discharge or inadequate discharge planning in the first admission necessitated the second admission
2. The readmission is part of a Medically Necessary, prior authorized or staged treatment plan
3. There is clear medical record documentation that the patient left the hospital AMA during the first hospitalization prior to completion of treatment and discharge planning.

Definitions

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

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

Non-Network Providers

Molina Healthcare maintains a contracted network of qualified healthcare professionals who have undergone a comprehensive credentialing process in order to provide medical care for Molina Healthcare Members. Molina Healthcare requires Members to receive medical care within the participating, contracted network of Providers unless it is for Emergency Services as defined by Federal Law. If there is a need to go to a non-contracted Provider, all care provided by non-contracted, non-network Providers must be prior authorized by Molina Healthcare. Non-network Providers may provide Emergency Services for a Member who is temporarily outside

the service area, without prior authorization or as otherwise required by Federal or State Laws or regulations.

Emergency Services" means health care procedures, treatments, observation, or services delivered to a covered person after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson, to result in:

- Jeopardy to the person's health or Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part
- Disfigurement to the person

Avoiding Conflict of Interest

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

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

Coordination of Care

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

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

Continuity of Care and Transition of Members

It is Molina Healthcare's policy to provide Members with advance notice when a Provider they are seeing will no longer be in network. Members and Providers are encouraged to use this time to transition care to an in-network Provider. The Provider leaving the network shall provide all appropriate information related to course of treatment, medical treatment, etc. to the Provider(s) assuming care. Under certain circumstances, Members may be able to continue treatment with the out of network Provider for a given period of time. For additional information regarding continuity of care and transition of Members, please contact Molina Healthcare at (855) 322-4082.

Continuity and Coordination of Provider Communication

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

Care Management

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

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

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

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

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

- High-risk pregnancy, including Members with a history of a previous preterm delivery
- Catastrophic medical conditions (e.g. neoplasm, organ/tissue transplants)
- Chronic illness (e.g. asthma, diabetes, End Stage Renal Disease)
- Preterm births
- High-technology home care requiring more than two weeks of treatment
- Member accessing ER services inappropriately
- Children with Special Health Care Needs
- Transitions of care for high risk members moving between levels of care

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

Phone: (800) 869-7185
Fax: (800) 767-7188

PCP Responsibilities in Care Management Referrals

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

Care Manager Responsibilities

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

Monitors and communicates the progress of the implemented plan of care to all involved resources

Serves as a coordinator and resource to team Members throughout the implementation of the plan, and makes revisions to the plan as suggested and needed

Coordinates appropriate education and encourages the Member's role in self-help

Monitors progress toward the Member's achievement of treatment plan goals in order to determine an appropriate time for the Member's discharge from the CM program.

Health Management and Disease Management Programs

Molina Healthcare's Health Management and Disease Management programs are offered to all members free of charge. No referral to receive these services is needed.

Emergency Services

Emergency Services means: health care procedures, treatments, observation, or services delivered to a covered person after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson, to result in:

- Jeopardy to the person's health or Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part
- Disfigurement to the person

Emergency services are covered on a (24) hour basis without the need for prior authorization for all Members experiencing an Emergency Medical Condition.

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

For Members within our service area: Molina Healthcare of Washington, Inc. contracts with vendors that provide (24) hour Emergency Services for ambulance and hospitals. An out of

network Emergency hospital stay will be covered until the Member has stabilized sufficiently to transfer to a Participating Provider facility. Services provided after stabilization in a Non-Participating Provider facility are not covered, and Member will be responsible for payment. Member payments to the Non-Participating Provider facility will not apply to the Member's Deductible or Annual Out-of-Pocket Maximum.

Medical Record Standards

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

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

Providers will develop and implement confidentiality procedures to guard Member protected health information, in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy standards and all other applicable Federal and State regulations. The Provider must ensure his/her staff receives periodic training regarding the confidentiality of Member information.

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

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

Medical Necessity Standards

"**Medically Necessary**" or "**Medical Necessity**" means health care services determined by a provider, in consultation with Molina Healthcare, to be clinically appropriate or clinically significant, in terms of type, frequency, event, site, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by Molina Healthcare consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, behavioral, or mental health condition, illness, injury, or disease.

Specialty Pharmaceuticals/Injectables and Infusion Services

Many self-administered and office-administered injectable products require Prior Authorization (PA). In some cases they will be made available through a vendor, designated by Molina Healthcare. More information about our Prior Authorization process, including a PA request form, is available in Section 7 of this manual.

Molina's pharmacy vendor will coordinate with Molina Healthcare and ship the prescription directly to your office or the Member's home. All packages are individually marked for each Member, and refrigerated drugs are shipped in insulated packages with frozen gel packs. The service also offers the additional convenience of enclosing needed ancillary supplies (needles,

syringes and alcohol swabs) with each prescription at no charge. Please contact your Provider Relations Representative with any further questions about the program.

Prior Authorization Guidelines and Request Form Marketplace effective 01/01/2016

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

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

This Prior Authorization/Pre-Service Guide applies to all Molina Marketplace Members

Refer to Molina's website or portal for specific codes that require authorization

Only covered services are eligible for reimbursement

- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Residential Treatment, Partial hospitalization, Day Treatment, Electroconvulsive Therapy (ECT)
- **Cosmetic, Plastic and Reconstructive Procedures (in any setting)**
- **Durable Medical Equipment:** Refer to Molina's Provider website or portal for specific codes that require authorization.
- **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
- **Habilitative Therapy –** After initial evaluation plus six (6) visits for outpatient and home settings (covered only for qualifying diagnosis)
- **Home Healthcare & Home Infusion:** After six (6) visits
- **Hyperbaric Therapy**
- **Imaging, Advanced and Specialty Imaging:** Refer to Molina's Provider website or portal for specific codes that require authorization
- **Inpatient Admissions: Acute hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility, Hospice** (Hospice requires notification only)
- **Neuropsychological and Psychological Testing**
- **Non-Par Providers/Facilities: Office visits, procedures, labs, diagnostic studies, inpatient stays except for:**
  - Emergency Department services
  - Professional fees associated with ER visit, approved Ambulatory Surgery Center (ASC) or inpatient stay
- **Office Visits and Procedures at PAR providers do not require prior authorization:** Refer to Molina's Provider website or portal for specific codes that require authorization
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures:** Refer to Molina's Provider website or portal for specific codes that require authorization
- **Pain Management Procedures**
- **Occupational Therapy/Physical Therapy/ Speech Therapy** Require authorization after initial evaluation plus 25 combined visits per calendar year.
- **Pregnancy and Delivery:** notification only
- **Prosthetics/Orthotics:** Refer to Molina's Provider website or portal for specific codes that require authorization
- **Radiation Therapy and Radiosurgery (for selected services only):** Refer to Molina's Provider website or portal for specific codes that require authorization
- **Sleep Studies (Except for Home Sleep Studies)**
- **Specialty Pharmacy drugs (oral and injectable):** Refer to Molina's Provider website or portal for specific codes that require authorization
- **Transplants including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization)
- **Transportation:** non-emergent ambulance (ground and air) ** For Covered Plans (Standard Renewal Plans, Not Choice Plans)
- **Unlisted & Miscellaneous Codes:** Molina requires standard codes when requesting authorization. Should an unlisted or miscellaneous code be requested, medical necessity documentation and rationale must be submitted with the prior authorization request.

IMPORTANT INFORMATION FOR MOLINA HEALTHCARE MARKETPLACE

Information generally required to support authorization decision making includes:

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

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

- If a request for services is denied, the requesting provider and the member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the provider by telephone, fax or electronic notification. Verbal, fax, or electronic denials are given within one business day of making the denial decision or sooner if required by the member's condition.
- Providers and members can request a copy of the criteria used to review requests for medical services.
- Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician at (425) 398-2603

Important Molina Healthcare Marketplace Information

Prior Authorizations: 8:00 a.m. – 5:00 p.m.
Phone: (800) 869-7165 Fax: (800) 767-7188
Radiology Authorizations:
Phone: (855) 714-2415 Fax: (877) 731-7218
NICU Authorizations:
Phone: (855) 714-2415 Fax: (877) 731-7218
Pharmacy Authorizations:
Phone: (800) 869-7185 Fax: (800) 869-7791
Behavioral Health Authorizations:
Phone: (800) 869-7185 Fax: (800) 767-7188
Transplant Authorizations:
Phone: (855) 714-2415 Fax: (877) 731-7218
Member Customer Service Benefits/Eligibility:
Phone: (888) 858-3492 Fax: (800) 816-3778
TTY/TDD: #711

Provider Customer Service: 8:00 a.m. – 5:00 p.m.
Phone: (888) 858-5414 Fax: (877) 814-0342

24 Hour Nurse Advice Line
English: 1 (888) 275-8750 [TTY: 1-866/735-2929]
Spanish: 1 (866) 648-3537 [TTY: 1-866/833-4703]
Vision Care:
Phone: (888) 493-4070 Fax: (866) 772- 0285
Dental:
Phone: (800) 869-7185 Fax: (866) 772-0285
Transportation:
Phone: (800) 869-7185 Fax: (800) 767-7188

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

- **Electronic authorization submission and status through Clear Coverage application with potential for automatic approval at the time of submission https://eportal.molinahealthcare.com/Provider/Login**
- **Claims Submission and Status**
- **Download Frequently Used Forms**
- **Member Eligibility**
- **Provider Directory Nurse Advice Line Report**

Molina Healthcare of Washington
Marketplace Prior Authorization Request Form
Phone Number: (800) 869-7185
Fax Number: (800) 767-7188

MEMBER INFORMATION				
Plan:		☐ **Molina Marketplace**		
Member Name:			**DOB:**	/ /
Member ID#:			**Phone:**	( ) -
Service Type:	☐ Elective/Routine		☐ Expedited/Urgent*	

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

	Referral/Service Type Requested	
Inpatient ☐ Surgical procedures ☐ ER Admits ☐ SNF ☐ Rehab ☐ LTAC	**Outpatient** ☐ Surgical Procedure ☐ PT/OT/STHabilitative Therapy ☐ Diagnostic Procedure ☐ Hyperbaric Therapy ☐ Infusion Therapy ☐ Other:	☐ **Home Health** ☐ **DME** ☐ **In Office**

Diagnosis Code & Description:			
CPT/HCPC Code & Description:			
Number of visits requested:		DOS:	From: / / to / /

Please send clinical notes and any supporting documentation

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

For Molina Use Only:

Section 7. Quality Improvement

Quality Improvement

Molina Healthcare of Washington maintains a Quality Improvement (QI) Department to work with Members and Providers in administering the Molina Quality Improvement Program. You can contact the Molina QI Department **toll free at (888) 562-5442**.

The address for mail requests is:

Molina Healthcare of Washington, Inc.
Quality Improvement Department
21540 30th Drive SE
Suite 140
Bothell, WA 98021

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

Molina has established a Quality Improvement (QI) Program that complies with regulatory and accreditation guidelines. The Quality Improvement Program provides structure and outlines specific activities designed to improve the care, service and health of our Members.

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

- Have a Quality Improvement Program in place;
- Comply with and participate in Molina Quality Improvement Program including reporting of Access and Availability and provision of medical records as part of the HEDIS® review process; and
- Allow access to Molina QI personnel for site and medical record review processes.

Medical Records

Molina requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to Members is consistently documented and that necessary information is readily available in the medical record. All entries will be indelibly added to the Member's record. Molina conducts a medical record review of all Primary Care Providers (PCPs) that have a 50 or more Member assignment that includes the following components:

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

Providers must demonstrate compliance with Molina Healthcare of Washington's medical record documentation guidelines. Medical records are assessed based on the following standards:

Content

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

Organization

- The medical record is legible to someone other than the writer;
- Each patient has an individual record;
- Chart pages are bound, clipped, or attached to the file; and
- Chart sections are easily recognized for retrieval of information.

Retrieval

- The medical record is available to Provider at each Encounter;

- The medical record is available to Molina Healthcare for purposes of Quality Improvement;
- The medical record is available to Office of Insurance Commissioner (OIC) and the External Quality Review Organization upon request;
- The medical record is available to the Member upon their request;
- Medical record retention process is consistent with State and Federal requirements; and
- An established and functional data recovery procedure in the event of data loss.

Confidentiality

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

Additional information on medical records is available from your local Molina Quality Improvement Department **toll free at (888) 562-5442**. See also the Compliance Section of this manual for additional information regarding the Health Insurance Portability and Accountability Act (HIPAA).

Access to Care

Molina is committed to timely access to care for all Members in a safe and healthy environment. Providers are required to conform to the Access to Care appointment standards listed below to ensure that health care services are provided in a timely manner. The standards are based on 95% availability for Emergency Services and 80% or greater for all other services. The PCP or his/her designee must be available 24 hours a day, 7 days a week to Members.

Appointment Access

All Providers who oversee the Member's health care are responsible for providing the following appointments to Molina Members in the timeframes noted:

Type of Care	Appointment Wait Time
Preventive Care Appointment	Within 30 calendar days of request
Routine Primary Care	Within 10 calendar days of request
Urgent Care	Within 48 hours
Emergency Care	Available by phone 24 hours/seven days
After-Hours Care	Available by phone 24 hours/seven days
Office Waiting Time	Should not exceed 30 minutes

Additional information on appointment access standards is available from your local Molina QI Department **toll free at (888) 562-5442**.

After Hours

All Providers must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a twenty-four (24) hour phone service, seven (7) days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with an Emergency to hang-up and call 911 or go immediately to the nearest emergency room.

Appointment Scheduling

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

1. The Provider must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments;
2. A process for documenting missed appointments must be established. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record and the Provider is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the medical record. If a second appointment is missed, the Provider is to notify the **Molina Member Services Department toll free at (800) 869-7165 or TTY:711**
3. When the Provider must cancel a scheduled appointment, the Member is given the option of seeing an associate or having the next available appointment time;
4. Special needs of Members must be accommodated when scheduling appointments. This includes, but is not limited to wheelchair-using Members and Members requiring language translation;
5. A process for Member notification of preventive care appointments must be established. This includes, but is not limited to immunizations and mammograms; and
6. A process must be established for Member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test results or the scheduling of procedures which must be performed prior to the next visit.

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

Women's Health Access

Molina allows Members the option to seek obstetrical and gynecological care from an in-network obstetrician or gynecologist or directly from a participating PCP designated by Molina Healthcare of Washington as providing obstetrical and gynecological services. Member access to obstetrical and gynecological services is monitored to ensure Members have direct access to Participating Providers for obstetrical and gynecological services.

Additional information on access to care is available under the Resources tab on the Molinahealthcare.com website or from your local Molina QI Department **toll free (888) 562-5442**.

Monitoring Access Standards

Molina monitors compliance with the established access standards above. At least annually, Molina conducts an access audit of randomly selected contracted Provider offices to determine if appointment access standards are met. One or all of the following appointment scenarios may be addressed: routine care; acute care; preventive care; and after-hours information. Results of

the audit are distributed to the Providers after its completion. A corrective action plan may be required if standards are not met.

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

Additional information on access to care is available under the Resources tab at Molinahealthcare.com or is available from your local Molina QI Department **toll free at (888) 562-5442**.

Site and Medical Record Keeping Practice Reviews

Molina Healthcare has a process to ensure that the offices of all Providers meet its office-site and medical record keeping practices standards. Molina Healthcare continually monitors Member complaints for all office sites to determine the need of an office site visit and will conduct office site visits within sixty (60) calendar days. Molina Healthcare assesses the quality, safety and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This form includes the Office Site Review Guidelines and the Medical Record Keeping Practice Guidelines outlined below and the thresholds for acceptable performance against the criteria. This includes an assessment of:

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

Physical accessibility

Molina Healthcare evaluates office sites to ensure that Members have safe and appropriate access to the office site. This includes, but is not limited to, ease of entry into the building, accessibility of space within the office site, and ease of access for physically disabled patients.

Physical appearance

The site visits includes, but is not limited to, an evaluation of office site cleanliness, appropriateness of lighting, and patient safety.

Adequacy of waiting and examining room space

During the site visit, Molina Healthcare assesses waiting and examining room spaces to ensure that the office offers appropriate accommodations to Members. The evaluation includes, but is not limited to, appropriate seating in the waiting room areas and availability of exam tables in exam rooms.

Adequacy of medical record-keeping practices

During the site-visit, Molina discusses office documentation practices with the Provider or Provider's staff. This discussion includes a review of the forms and methods used to keep the information in a consistent manner and includes how the practice ensures confidentiality of records. Molina assesses one medical/treatment record for orderliness of record and

documentation practices. To ensure Member confidentiality, Molina reviews a “blinded” medical/treatment record or a “model” record instead of an actual record.

OFFICE SITE REVIEW GUIDELINES AND COMPLIANCE STANDARDS

Provider office sites must demonstrate an overall 80% compliance with the Office Site Review Guidelines listed below. If a serious deficiency is noted during the review but the office demonstrates overall compliance, a follow-up review may be required at the discretion of the Site Reviewer to ensure correction of the deficiency.

Facility

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted and parking area and walkways demonstrate appropriate maintenance.
- Handicapped parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is handicapped accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two office exam rooms per physician.

Safety

- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- At least one CPR certified employee is available
- Yearly OSHA training (Fire, Safety, Blood borne Pathogens, etc.) is documented for offices with 10 or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, and contracts evidence hazardous waste management.

Administration & Confidentiality

- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers or labels are possible alternative methods.
- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.
- Medical records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked.
- A CLIA waiver is displayed when the appropriate lab work is run in the office.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double locked. Medication and sample access is restricted.
- System in place to ensure expired sample medications are not dispensed and injectibles and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

MEDICAL RECORD KEEPING PRACTICE GUIDELINES AND COMPLIANCE STANDARDS

Provider medical record keeping practices must demonstrate an overall 80% compliance with the Medical Record Keeping Practice Guidelines listed below. If a serious deficiency is noted during the review but the office demonstrates overall compliance, a follow-up review may be required at the discretion of the Site Reviewer to ensure correction of the deficiency.

- Each patient has a separate medical record. File markers are legible. Records are stored away from patient areas and preferably locked. Record is available at each patient visit. Archived records are available within 24-hours.
- Pages are securely attached in the medical record. Computer users have individual passwords.
- Medical records are organized by dividers or color-coding when the thickness of the record dictates.
- A chronic problem list is included in the record for all adults and children.
- Allergies (and the lack of allergies) are prominently displayed at the front of the record.
- A complete health history questionnaire or H&P is part of the record.
- Health Maintenance forms includes dates of preventive services.
- A medication sheet is included for chronic medications.
- Advance Directives discussions are documented for those 18 years and older.
- Record keeping is monitored for Quality Improvement and HIPAA compliance.
- Within 30 calendar days of the review, a copy of the site review report, the medical record keeping practices report and a letter will be sent to the medical group notifying them of their results.

Improvement Plans/Corrective Action Plans

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

- Send a letter to the Provider that identifies the compliance issues.
- Send sample forms and other information to assist the Provider to achieve a passing score on the next review.
- Request the Provider to submit a written corrective action plan to Molina within 30 calendar days.
- Send notification that another review will be conducted of the office in six months.

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

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

Providers who do not submit a CAP may be terminated from network participation. Any further action is conducted in accordance with the Molina Fair Hearing Plan policy. For any questions related to office site visit review contact the local Molina QI Department **toll free at** (888) 562-5442.

Advance Directives (Patient Self-Determination Act)

Advance Directives

Providers must inform adult Molina Members (18 years old and up) of their right to make health care decisions and execute Advance Directives. It is important that Members are informed about Advance Directives. During routine Medical Record review, Molina Healthcare auditors will look for documented evidence of discussion between the Provider and the Member. Molina will notify the Provider via fax of an individual Member's Advance Directives identified through Care Management, Care Coordination or Case Management. Providers are instructed to document the presence of an Advance Directive in a prominent location of the Medical Record. Auditors will also look for copies of the Advance Directive form. Advance Directives forms are State specific to meet State regulations.

Each Molina Provider must honor Advance Directives to the fullest extent permitted under Law. Members may select a new PCP if the assigned Provider has an objection to the beneficiary's desired decision. Molina Healthcare will facilitate finding a new PCP or specialist as needed**.**

PCPs must discuss Advance Directives with a Member and provide appropriate medical advice if the Member desires guidance or assistance. Molina's network Providers and facilities are expected to communicate any objections they may have to a Member directive prior to service whenever possible. In no event may any Provider refuse to treat a Member or otherwise discriminate against a Member because the Member has completed an Advance Directive. CMS Law gives Members the right to file a complaint with Molina Healthcare or the State survey and certification agency if the Member is dissatisfied with Molina Healthcare's handling of Advance Directives and/or if a Provider fails to comply with Advance Directives instructions.

Advance Directives are a written choice for health care. There are three types of Advance Directives:

- Durable Power of Attorney for Health Care: allows an agent to be appointed to carry out health care decisions
- Living Will: allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration
- Guardian Appointment: allows one to nominate someone to be appointed as Guardian if a court determines that a guardian is necessary

When There Is No Advance Directive: The Member's family and Provider will work together to decide on the best care for the Member based on information they may know about the Member's end-of-life plans.

Services to Enrollees Under Twenty-One (21) Years

Molina Healthcare maintains systematic and robust monitoring mechanisms to ensure all Enrollees under twenty-one (21) Years are timely according to required preventive health guidelines. All Enrollees under twenty-one (21) years of age should receive screening

examinations including appropriate childhood immunizations at intervals as specified by the by the preventive health guidelines located on the Molina Healthcare Website (www.molinahealthcare.com) and referenced in the Benefits and Covered Services section of this manual.

Well child / adolescent visits

Visits consist of age appropriate components including but not limited to:

- comprehensive health and developmental history;
- nutritional assessment;
- height and weight and growth charting;
- comprehensive unclothed physical examination;
- appropriate immunizations;
- laboratory procedures, including lead blood level assessment appropriate for age and risk factors;
- periodic developmental and behavioral screening;
- vision and hearing tests;
- dental assessment and services;
- health education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention);
- perinatal depression for mothers of infants in the most appropriate clinical setting, e.g., at the pediatric, behavioral health or OB/GYN visit.

Diagnostic services, treatment, or services Medically Necessary to correct or ameliorate defects, physical or mental illnesses, and conditions discovered during a screening or testing must be provided or arranged for either directly or through referrals. Any condition discovered during the screening examination or screening test requiring further diagnostic study or treatment must be provided if within the Member's Covered Benefit Services. Members should be referred to an appropriate source of care for any required services that are not Covered Services.

Molina shall have no obligation to pay for services that are not Covered Services.

Monitoring for Compliance with Standards

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

Quality Improvement Activities and Programs

Molina maintains an active Quality Improvement Program (QIP). The QIP provides structure and key processes to carry out our ongoing commitment to improvement of care and service. The

goals identified are based on an evaluation of programs and services; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

Clinical Practice Guidelines

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

Molina Clinical Practice Guidelines include the following:

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

The adopted Clinical Practice Guidelines are distributed to the appropriate Providers, Providers, Provider groups, staff model facilities, delegates and Members by the Quality Improvement, Provider Services, Health Education and Member Services Departments. The guidelines are disseminated through Provider newsletters, Just the Fax electronic bulletins and other media and are available on the Molina Healthcare Website. Individual Providers or Members may request copies from your local Molina Healthcare QI Department **toll free at (888) 562-5442**.

Preventive Health Guidelines

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

- Mammography screening;
- Prostate cancer screening;
- Cholesterol screening;
- Influenza, pneumococcal and hepatitis vaccines.
- Childhood and adolescent immunizations;
- Cervical cancer screening;
- Chlamydia screening;
- Prenatal visits.

All guidelines are updated with each release by USPSTF and are approved by the Quality Improvement Committee. On annual basis, Preventive Health Guidelines are distributed to Providers via www.molinahealthcare.com and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Provider Newsletter.

Cultural and Linguistic Services

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

24 Hour Access to Interpreter

Providers may request assistance in interpreting for Members whose primary language is other than English by calling **Molina Healthcare toll free at (800) 869-7175.** If Member Services Representatives are unable to provide the interpretation services internally, the Member and Provider are immediately connected to a Language Line telephonic interpreter service.

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

Additional information on cultural and linguistic services is available at www.molinahealthcare.com and from your local Provider Services Representatives and from the Molina Member and Provider Services Departments.

Measurement of Clinical and Service Quality

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

- Healthcare Effectiveness Data and Information Set (HEDIS®);
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®);
- Experience of Care and Health Outcomes (ECHO®)
- Provider Satisfaction Survey; and
- Effectiveness of Quality Improvement Initiatives.

Molina Healthcare evaluates continuous performance according to, or in comparison with objectives, measurable performance standards and benchmarks at the national, regional and/or at the local/health plan level.

Contracted Providers and Facilities must allow Molina Healthcare to use its performance data collected in accordance with the Provider's or facility's contract. The use of performance data

may include, but is not limited to, the following: (1) development of Quality Improvement activities; (2) public reporting to consumers; (3) preferred status designation in the network; (4) and/or reduced Member cost sharing.

Molina' Healthcare's most recent results can be obtained from your local Molina Healthcare QI Department **toll free at (888) 562-5442**.

HEDIS®

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

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

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

CAHPS®

CAHPS® is the tool used by Molina to summarize Member satisfaction with the health care and service they receive. CAHPS® examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Health Promotion and Education, Coordination of Care and Customer Service. The CAHPS® survey is administered annually in the spring to randomly selected Members by a NCQA certified vendor.

CAHPS® results are used in much the same way as HEDIS® results, only the focus is on the service aspect of care rather than clinical activities. They form the basis for several of Molina's Quality Improvement activities and are used by external agencies to help ascertain the quality of services being delivered.

ECHO® Survey

The Experience of Care and Health Outcomes (ECHO®) 3.0 Survey is an NCQA endorsed tool that assesses the experience, needs, and perceptions of Members with their behavioral health care. Similar to CAHPS®, the ECHO® survey for adults produce the following measures of patient experience:

- Getting treatment quickly
- How well clinicians communicate
- Getting treatment and information from the plan
- Perceived improvement
- Information about treatment options
- Overall rating of counseling and treatment

- Overall rating of the health plan

The ECHO® Survey will be administered annually to selected Members by an NCQA-certified vendor.

Provider Satisfaction Survey

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

Effectiveness of Quality Improvement Initiatives

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

Section 8. Claims

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

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

Claim Submission

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

Molina Healthcare of Washington, Inc.
PO Box 22612
Long Beach, CA 90801

Providers billing Molina Healthcare electronically should use current HIPAA compliant ANSI X12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims) and use electronic payor ID number: 38336.

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

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

- Physicians and Other Professional Providers:
    - The Centers for Medicare and Medicaid Services (CMS) Form 1500 or its successor adopted by the National Uniform Claim Committee (NUCC) submitted on the designated paper or electronic format. Current Procedural Terminology (CPT) codes and modifiers and International Classification of Diseases (ICD) codes. Entries states as mandatory by NUCC and required by Federal statute and regulation and any State designated data requirements included in statutes or regulations.

National Provider Identifier (NPI)

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

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

Electronic Claim Submissions and Claims Payment

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

Electronic Claims Submission Options

Molina Healthcare encourages Providers to submit Claims electronically. Electronic Claims submission provides significant benefits to the Provider including:

- Reduction in operational costs associated with paper Claims (printing, postage, etc.)
- Ensures HIPAA Compliance
- Increased accuracy of data and efficient information delivery
- Reduction in Claims delays (since errors can be corrected and re-submitted electronically)
- Claims reach Molina Healthcare faster, since there is no mailing time

Molina Healthcare offers the following electronic Claims submission options:

- Submit Claims directly to Molina Healthcare of Washington via the Provider Portal
- Submit Claims to Molina Healthcare via your regular EDI clearinghouse using Payor ID 38336

Molina Healthcare uses Emdeon/Change Healthcare as its gateway clearinghouse. Emdeon/Change Healthcare has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit Claims to their usual clearinghouse. Emdeon/Change Healthcare will receive those Claims on behalf of Molina Healthcare.

Molina Healthcare accepts EDI transactions for Claims via the 837P for Professional and 837I for institutional. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure Claims are received for processing in a timely manner.

When your Claims are filed electronically:

- You should receive an acknowledgement from your current clearinghouse
- You should receive a 999 and 277 acknowledgement from your clearinghouse

- You should contact your local clearinghouse representative if you experience any problems with your transmission

EDI Claims Submission Issues

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

Electronic Remittance Advice and Electronic Funds Transfer: To register please go to https://providernet.adminisource.com. If you have any questions regarding the actual registration process, please contact FIS/ProviderNet at (877) 389-1160 or email Provider.Services@fisglobal.com.

Timely Claim Filing

Provider shall promptly submit to Molina Healthcare Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina Healthcare, and shall include any and all medical records pertaining to the Claim if requested by Molina Healthcare or otherwise required by Molina Healthcare's policies and procedures. Claims must be submitted by Provider to Molina Healthcare based on their contractual requirements or within one-hundred and twenty calendar days after the following have occurred: discharge for inpatient services or the Date of Service for outpatient services; and Provider has been furnished with the correct name and address of the Member's health maintenance organization. If Molina Healthcare is not the primary payer under coordination of benefits or third party liability, Provider must submit Claims to Molina Healthcare within one-hundred and eighty (180) calendar days after final determination by the primary payer. Except as otherwise provided by Law or provided by Government Program requirements, any Claims that are not submitted to Molina Healthcare within these timelines shall not be eligible for payment and Provider hereby waives any right to payment therefore.

Fraud and Abuse

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

Timely Claim Processing

Claims payment will be made to contracted Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Molina Healthcare or contracted medical group/IPA have agreed in writing to an alternate payment schedule, Molina Healthcare will pay the Provider of service as soon as possible after receipt of Clean Claims. Payment is subject to the following minimum standard as set forth by the Office of the Insurance Commissioner (OIC):

- Ninety-five (95%) percent of the monthly volume of "clean" claims will be adjudicated within 30 calendar days of receipt by Molina Healthcare. A "clean" claim has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.

- Ninety-five (95%) percent of the monthly volume of claims shall be paid or denied within 60 calendar days of receipt by Molina Healthcare.

- Ninety-nine (99%) percent of all claims shall be paid or denied within 90 calendar days of receipt by Molina Healthcare.

The receipt date of a claim is the date Molina Healthcare receives either written or electronic notice of the claim. All hard copy claims received by Molina Healthcare will be clearly stamped with date of receipt. If Molina Healthcare fails to abide by the timely claims payment standards stated above, Molina Healthcare is required to pay interest on undenied and unpaid clean claims as described in WAC 284-43-321.

Claim Editing Process

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

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

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

Coordination of Benefits and Third Party Liability

For Members enrolled in a Molina Marketplace plan, Molina Healthcare and/or contracted Medical Groups/IPAs are financially responsible for the care provided to these Members. Molina Marketplace will pay Claims for Covered Services, however if TPL/COB is determined post payment, Molina Marketplace will attempt to recover any Overpayments.

Claim Review

Claims will be reviewed and paid in accordance with industry standard billing and payment rules, including, but not limited to, current Uniform Billing ("UB") manual and editor, Current Procedural Terminology ("CPT") and Healthcare Common Procedure Coding System ("HCPCS"), Federal, and State billing and payment rules, National Correct Coding Initiative ("NCCI") Edits, and Federal Drug Administration ("FDA") definitions and determinations of designated implantable devices and/or implantable orthopedic devices. Furthermore, Provider acknowledges Molina Healthcare's right to conduct Medical Necessity reviews and apply clinical practices to determine appropriate payment. Payment may exclude certain items not billed in accordance with industry standard billing and payment rules or certain items which do not meet certain Medical Necessity criteria.

Claim Auditing

Provider acknowledges Molina Healthcare's right to conduct post-payment billing audits. Provider shall cooperate with Molina Healthcare's audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical records,

Provider's charging policies, and other related data. Molina Healthcare shall use established industry Claims adjudication and/or clinical practices, State, and Federal guidelines, and/or Molina Healthcare's policies and data to determine the appropriateness of the billing, coding, and payment.

Corrected Claims

Corrected Claims are considered new Claims. Corrected Claims may be submitted electronically with the appropriate field on the 837I or 837P completed. Paper corrected Claims need to be marked as corrected and should be submitted to the following address (subject to timely filing requirements):

Molina Healthcare of Washington, Inc.
PO Box 22612
Long Beach, CA 90801

Claims Disputes/Reconsiderations

Providers disputing a Claim previously adjudicated must request such action within twenty four (24) months of Molina Healthcare's original remittance advice date. Additionally, the item(s) being resubmitted should be clearly marked as reconsideration and must include the following:

- The previous Claim and remittance advice, any other documentation to support the adjustment and a copy of the Referral/Authorization form (if applicable) must accompany the adjustment request.
- The Claim number clearly marked on all supporting documents

Disputes may be submitted via fax, mail or e-mail.:

Molina Healthcare of Washington, Inc.
Attention: Provider Services
PO Box 4004
Bothell, WA 98041-4004

Fax: (877) 814-0342

Email: MHWProviderServicesInternalRep@Molinahealthcare.com

Please Note: Requests for adjustments or reconsideration of Claims paid by a delegated medical group/IPA must be submitted to the group responsible for payment of the original Claim.

The Provider will be notified of Molina Healthcare's decision in writing within sixty (60) days of receipt of the Claims Dispute.

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of coverage decisions or payment levels, Molina Healthcare determines that it has made an Overpayment to a Provider for services rendered to a Member,

it will make a Claim for such Overpayment. Molina Healthcare will not reduce payment to that Provider for other services unless the Provider agrees to the reduction or fails to respond to Molina Healthcare's Claim as required in this subsection.

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

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

Billing the Member

Molina Healthcare contracted Providers may collect applicable Cost Sharing including co-payments, deductible, and coinsurance from the Member as required by the agreement. The contract between the Provider and Molina Healthcare places the responsibility for verifying eligibility and obtaining approval for those services that require prior authorization on the Provider.

Encounter Data

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

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

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

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

When your Encounters are filed electronically you should receive:

- For any direct submission to Molina you should receive a 999 acknowledgement of your transmission
- For Encounter submission you will also receive a 277CA response file for each transaction

Section 9. Compliance

Fraud, Waste, and Abuse

Introduction

Molina Healthcare of Washington maintains a comprehensive Fraud, Waste, and Abuse program. The program is held accountable for the special investigative process in accordance with Federal and State statutes and regulations. Molina Healthcare of Washington is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, the Compliance department maintains a comprehensive plan, which addresses how Molina Healthcare of Washington will uphold and follow State and Federal statutes and regulations pertaining to fraud, waste, and abuse. The program also addresses fraud prevention and the education of appropriate employees, vendors, Providers and associates doing business with Molina Healthcare of Washington.

Mission Statement

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

Regulatory Requirements

Federal False Claims Act

The False Claims Act is a Federal statute that covers fraud involving any Federally funded contract or program. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent Claim to the U.S. Government for payment.

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

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

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

DEFINITIONS

Fraud:

“Fraud” means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State Law.

Waste:

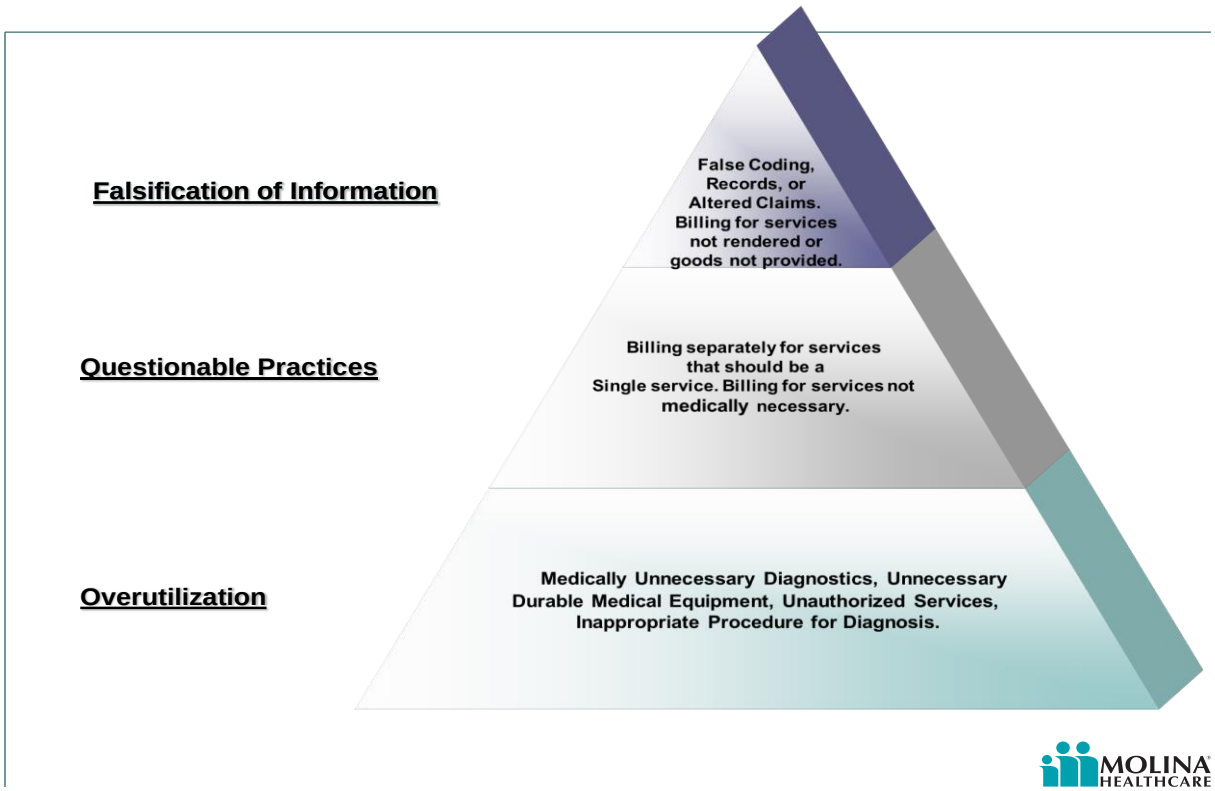
Health care spending that can be eliminated without reducing the quality of care. Quality Waste includes, overuse, underuse, and ineffective use. Inefficiency Waste includes redundancy, delays, and unnecessary process complexity. For example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of poor or inefficient billing methods (e.g. coding) causes unnecessary costs.

Abuse:

"Abuse" means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Marketplace program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost.

Examples of Fraud, Waste and Abuse by a Provider

- Billing for services, procedures and/or supplies that have not actually been rendered.
- Providing services to patients that are not Medically Necessary.
- Balance Billing a Marketplace Member for Marketplace Covered Services. For example, asking the patient to pay the difference between the discounted fees, negotiated fees, and the Provider's usual and customary fees.
- Intentional misrepresentation or manipulating the benefits payable for services, procedures and or supplies, dates on which services and/or treatments were rendered, medical record of service, condition treated or diagnosed, charges or reimbursement, identity of Provider or the recipient of services, "unbundling" of procedures, non-covered treatments to receive payment, "up-coding," and billing for services not provided.
- Concealing patients misuse of Molina Healthcare of Washington identification card.
- Failure to report a patient's forgery/alteration of a prescription.
- Knowingly and willfully soliciting/receiving payment of kickbacks or bribes in exchange for the referral of Marketplace patients.



Examples of Fraud, Waste, and Abuse by a Member

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 Marketplace benefits.
- Conspiracy to defraud the Marketplace.
- 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.
- 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.

Review of Provider Claims and Claims System

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

The Claims payment system utilizes system edits and flags to validate those elements of Claims are billed in accordance with standardized billing practices; ensure that Claims are processed accurately and ensure that payments reflect the service preformed as authorized.

Molina Healthcare of Washington performs auditing to ensure the accuracy of data input into the Claims system. The Claims department conducts regular audits to identify system issues or

errors. If errors are identified, they are corrected and a thorough review of system edits is conducted to detect and locate the source of the errors.

Prepayment Fraud, Waste, and Abuse Detection Activities

Through implementation of Claims edits, Molina Healthcare's Claims payment system is designed to audit Claims concurrently, in order to detect and prevent paying Claims that are inappropriate.

Post-payment Recovery Activities

The terms expressed in this section of this Provider Manual are incorporated into the Provider Agreement, and are intended to supplement, rather than diminish, any and all other rights and remedies that may be available to Molina Healthcare under the Provider Agreement or at Law or equity. In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement, the parties agree that Molina Healthcare shall in its sole discretion exercise the terms that are expressed in the Provider Agreement, the terms that are expressed here, its rights under Law and equity, or some combination thereof.

Provider will provide Molina Healthcare, governmental agencies and their representatives or agents, access to examine, audit, and copy any and all records deemed by Molina Healthcare, in Molina Healthcare's sole discretion, necessary to determine compliance with the terms of the Provider Agreement, including for the purpose of investigating potential fraud, waste and abuse. Documents and records must be readily accessible at the location where Provider provides services to any Molina Healthcare Members. Auditable documents and records include, but are not limited to, medical charts; patient charts; billing records; and coordination of benefits information. Production of auditable documents and records must be provided in a timely manner, as requested by Molina Healthcare and without charge to Molina Healthcare. In the event Molina Healthcare identifies fraud, waste or abuse, Provider agrees to repay funds or Molina Healthcare may seek recoupment.

If a Molina Healthcare auditor is denied access to Provider's records, all of the Claims for which Provider received payment from Molina Healthcare is immediately due and owing. If Provider fails to provide all requested documentation for any Claim, the entire amount of the paid Claim is immediately due and owing. Molina Healthcare may offset such amounts against any amounts owed by Molina Healthcare to Provider. Provider must comply with all requests for documentation and records timely (as reasonably requested by Molina Healthcare) and without charge to Molina Healthcare. Claims for which Provider fails to furnish supporting documentation during the audit process are not reimbursable and are subject to chargeback.

Provider acknowledges that HIPAA specifically permits a covered entity, such as Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 154.501). Provider further acknowledges that in order to receive payment from Molina Healthcare, Provider is required to allow Molina Healthcare to conduct audits of its pertinent records to verify the services performed and the payment claimed, and that such audits are permitted as a payment activity of Provider under HIPAA and other applicable privacy Laws.

Review of Provider

The Credentialing Department is responsible for monitoring Providers through the various Government reports, including:

- Federal and State sanction reports.
- Federal and State lists of excluded individuals and entities including the Washington Provider Termination and Exclusion list maintained by the Health Care Authority and found at: http://www.hca.wa.gov/medicaid/provider/Pages/termination.aspx
- List of parties excluded from Federal Procurement and Non-procurement Programs.
- Monthly review of State Medical Board sanctions list.
- Review of license reports from the appropriate specialty board.

If a match is found, the Credentialing Services staff will request copies of relevant information from the appropriate Government entity. Upon receiving this information the documents are presented to the Credentialing Committee for review and potential action. The Credentialing staff will also present the list of physicians found on the sanctions report to the Compliance Committee for review and potential oversight of action.

Provider Education

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

The Molina Healthcare of Washington Provider Services Representative will inform the Provider's office that an on-site meeting is required in order to educate the Provider on certain issues identified as inappropriate or deficient.

Reporting Fraud, Waste and Abuse

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

Molina Healthcare AlertLine can be reached toll free at 1-866-606-3889 or you may use the service's website to make a report at any time at **https://molinahealthcare.alertline.com**

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

Molina Healthcare of Washington
Attn: Compliance
PO Box 4004
Bothell, WA 98041-4004

Molina Healthcare of Washington Confidential Fax: (800) 282-9929

Remember to include the following information when reporting:

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

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

Washington State Healthcare Authority
Attn: Office of Program Integrity
626 8th Ave SE/ PO Box 45503
Olympia, WA 98504-5503

Fax (360) 586-0212

HIPAA Requirements and Information

HIPAA (The Health Insurance Portability and Accountability Act)

Molina Healthcare's Commitment to Patient Privacy

Protecting the privacy of Members' personal health information is a core responsibility that Molina Healthcare takes very seriously. Molina Healthcare is committed to complying with all Federal and State Laws regarding the privacy and security of Members' protected health information (PHI).

Provider Responsibilities

Molina Healthcare expects that its contracted Provider will respect the privacy of Molina Healthcare Members (including Molina Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member PHI.

Applicable Laws

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, which may include, but are not limited to, the following:

1. Federal Laws and Regulations
   - HIPAA
   - The Health Information Technology for Economic and Clinical Health Act (HITECH)
   - Medicare and Medicaid Laws
   - The Affordable Care Act
2. Applicable State Laws and Regulations

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

Uses and Disclosures of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable Law. Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment, and healthcare operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity[1]. Disclosure of PHI by one covered entity to another covered entity, or healthcare Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a healthcare Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services[2]."

2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:
   - Quality improvement;
   - Disease management;
   - Case management and care coordination;
   - Training Programs;
   - Accreditation, licensing, and credentialing

Importantly, this allows Providers to share PHI with Molina Healthcare for our healthcare operations activities, such as HEDIS and Quality Improvement.

Inadvertent Disclosures of PHI

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

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

[2] See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

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 Provider's practice:

1. **Notice of Privacy Practices**

   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 the notice of privacy practices.

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 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 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 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 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

Providers should implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of Molina Member and patient PHI. As more Providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate cyber security measures. Providers should recognize that identity theft – both financial and medical -- is a rapidly growing problem and that their patients trust their health care Providers to keep their most sensitive information private and confidential..

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

HIPAA Transactions and Code Sets

Molina Healthcare strongly supports the use of electronic transactions to streamline healthcare administrative activities. Molina Healthcare Providers are encouraged to submit Claims and other transactions to Molina Healthcare using electronic formats. Certain electronic transactions in health care are subject to HIPAA's Transactions and Code Sets Rule including, but not limited to, the following:

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

Molina Healthcare is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers who wish to conduct HIPAA standard transactions with Molina Healthcare you should visit our website at www.MolinaHealthcare.com to view additional information. Providers can navigate to this informative page starting from Molina's website:

1. Select the area titled "For Health Care Professionals"
2. From the top of the web page, click the tab titled "HIPAA"
3. Click on the tab titled "HIPAA Transaction Readiness."

Code Sets

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

About ICD-10

ICD-10-CM/PCS (International Classification of Diseases, 10th Edition, Clinical Modification /Procedure Coding System) consists of two parts:

1. ICD-10-CM for diagnosis coding

2. ICD-10-PCS for inpatient procedure coding

ICD-10-CM is for use in all U.S. health care settings. Diagnosis coding under ICD-10-CM uses 3 to 7 digits instead of the 3 to 5 digits used with ICD-9-CM, but the format of the code sets is similar.

ICD-10-PCS is for use in U.S. inpatient hospital settings only. ICD-10 PCS uses 7 alphanumeric digits instead of the 3 or 4 numeric digits used under ICD-9-CM procedure coding. Coding under ICD-10-PCS is much more specific and substantially different from ICD-9-CM procedure coding.

The transition to ICD-10 is occurring because ICD-9 produces limited data about patients' medical conditions and hospital inpatient procedures. ICD-9 is 30 years old, has outdated terms, and is inconsistent with current medical practice. Also, the structure of ICD-9 limits the number of new codes that can be created, and many ICD-9 categories are full.

National Provider Identifier

Provider must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider. 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. Providers must use their NPI to identify it on all electronic transactions required under HIPAA and on all Claims and Encounters (both electronic and paper formats) submitted to Molina Healthcare.

Additional Requirements for Delegated Providers

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.

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Member Name:_____ Member ID #:_____

Member Address:_____ Date of Birth:_____

City/State/Zip:_____ Telephone #:_____

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

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

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

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

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

7. Molina Healthcare may condition the provision of research related treatment on my provision of an authorization for the use or disclosure of PHI for such research.

8. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, Molina Healthcare reserves the right to deny that health care.

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

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

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

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

    _____

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

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

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

Section 10. Credentialing and Recredentialing

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

The decision to accept or deny a credentialing applicant is based upon primary source verification, recommendation of peer Providers and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under State and Federal Law.

The Credentialing Program has been developed in accordance with State and Federal requirements and accreditation guidelines. In accordance with those standards, Molina Healthcare Members will not be referred and/or assigned to you until the credentialing process has been completed.

Criteria for Participation in the Molina Healthcare Network

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

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

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

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

1. Provider must practice, or plan to practice within 90 calendar days, within the area served by Molina.
2. All Providers, including ancillary Providers, (i.e. vision, pharmacy, etc.), will apply for enrollment in the Medicaid program. Providers are required to have an NPI or an Administrative Provider Identification Number (APIN).

3. Provider must complete and submit to Molina a credentialing application. The application must be entirely complete. The Provider must sign and date that application attesting that their application is complete and correct within 180 calendar days of the credentialing decision. If Molina or the Credentialing Committee requests any additional information or clarification the Provider must supply that information in the time-frame requested.
4. Provider must have a current, valid license to practice in their specialty in every State in which they will provide care for Molina Members.
5. If applicable to the specialty, Provider must hold a current and unrestricted Federal Drug Enforcement Agency (DEA) certificate and Controlled Substance Certification or Registration. If a Provider has never had any disciplinary action taken related to his/her DEA or CDS and chooses not to have a DEA or CDS, the Provider may be considered for network participation if they submit a written prescription plan describing the process for allowing another Provider with a valid DEA or CDS certificate to write all prescriptions. If a Provider does not have a DEA because of disciplinary action including but not limited to being revoked or relinquished, the Provider is not eligible to participate in the Molina network.
6. Providers will only be credentialed in an area of practice in which they have adequate education and training as outlined below. Therefore Providers must confine their practice to their credentialed area of practice when providing services to Molina Members.
7. Providers must have graduated from an accredited school with a degree required to practice in their specialty.
8. Oral Surgeons and Physicians (MDs, DOs) must have satisfactorily completed a training program from an accredited training program in the specialty in which they are practicing. Molina only recognizes training programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must have completed a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA).
9. Board certification in the specialty in which the Provider is practicing is preferred but not required. Initial applicants who are not Board Certified may be considered for participation only if they have satisfactorily completed a training program from an accredited training program in the specialty in which they are practicing. Molina recognizes Board Certification only from the following Boards:
    a. American Board of Medical Specialties (ABMS)
    b. American Osteopathic Association (AOA)
    c. American Board of Podiatric Surgery (ABPS)
    d. American Board of Podiatric Medicine (ABPM)
    e. American Board of Oral and Maxillofacial Surgery
10. Providers who are not Board Certified and have not completed a training program from an accredited training program are only eligible to be considered for participation as a General Provider in the Molina network. To be eligible, the Provider must have maintained a Primary Care practice in good standing for a minimum of the most recent five years without any gaps in work history.

11. Provider must supply a minimum of 5-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If the Provider has practiced fewer than 5-years from the date of Credentialing, the work history starts at the time of initial licensure. Experience practicing as a non-physician health professional (e.g. registered nurse, nurse practitioner, clinical social worker) within the 5-years should be included. If Molina determines there is a gap in work history exceeding six-months, the Provider must clarify the gap either verbally or in writing. Verbal communication must be appropriately documented in the credentialing file. If Molina determines there is a gap in work history that exceeds one-year, the Provider must clarify the gap in writing.
12. Provider must supply a full history of malpractice and professional liability Claims and settlement history. Documentation of malpractice and professional liability Claims and settlement history is requested from the Provider on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.
13. Provider must disclose a full history of all license actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations and non-renewals. Provider must also disclose any history of voluntarily relinquishing, withdrawing, or failure to proceed with an application in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.
14. At the time of initial application, the Provider must not have any pending or open investigations from any State or governmental professional disciplinary body.[3]. This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.
15. Provider must disclose all Medicare and Medicaid sanctions. Provider must disclose all debarrements, suspensions, proposals for debarments, exclusions or disqualifications under the nonprocurement common rule, or when otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.
16. Provider must not be currently sanctioned, excluded, expelled or suspended from any State or Federally funded program including but not limited to the Medicare or Medicaid programs.
17. Provider must have and maintain current professional malpractice liability coverage with limits that meet Molina criteria. This coverage shall extend to Molina Members and the Providers activities on Molina's behalf.

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

18. Provider must disclose any inability to perform essential functions of a Provider in their area of practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.
19. Provider must disclose if they are currently using any illegal drugs/substances. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider. If a Provider discloses any issues with substance abuse (e.g. drugs, alcohol) the Provider must provide evidence of either actively and successfully participating in a substance abuse monitoring program or successfully completing a program.
20. Provider must disclose if they have ever had any criminal convictions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.
21. Provider must not have been convicted of a felony or pled guilty to a felony for a healthcare related crime including but not limited to healthcare fraud, patient abuse and the unlawful manufacture distribution or dispensing of a controlled substance.
22. Provider must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Provider has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.
23. Physicians (MD, DO), Primary Care Providers, Nurse Midwives, Oral Surgeons, Podiatrists and/or those Providers dictated by State Law, must have admitting privileges in their specialty. If a Provider chooses not to have admitting privileges, the Provider may be considered for network participation if they have a plan for hospital admission by using a Hospital Inpatient Team or having an arrangement with a credentialed Molina participating Provider that has the ability to admit Molina patients to a hospital. Providers practicing exclusively on a consultative basis are not required to have admitting hospital privileges. Physicians practicing in Dermatology, Occupational Medicine, Pain Medicine, Physical Medicine and Rehabilitation, Psychiatry, Sleep Medicine, Sports Medicine, Telemedicine, Urgent Care and Wound Management do not require admitting privileges.
24. Providers not able to practice independently according to State Law must have a practice plan with a supervising physician approved by the State licensing agency. The supervising physician must be contracted and credentialed with Molina.
25. Providers currently listed on the Medicare Opt-Out Report may not participate in the Molina network for any Medicare line of business.
26. If applicable to the specialty, Provider must have a plan for shared call coverage that includes 24-hours a day, seven days per week and 365 days per year. The covering Provider(s) must be qualified to assess over the phone if a patient should immediately seek medical attention or if the patient can wait to be seen on the next business day. All Primary Care Providers must have 24-hour coverage. Physicians practicing in Dermatology, Occupational Medicine, Pain Medicine, Physical Medicine and Rehabilitation, Sleep Medicine, Telemedicine, Sports Medicine, Urgent Care and Wound Management are not required to have 24-hour coverage.
27. Molina may determine, in its sole discretion, that a Provider is not eligible to apply for network participation if the Provider is an employee of a Provider or an employee of a company owned in whole or in part by a Provider, who has been denied or terminated

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

28. Providers denied by the Credentialing Committee are not eligible to reapply until one year after the date of denial by the Credentialing Committee. At the time of reapplication, Provider must meet all criteria for participation outlined above.
29. Providers terminated by the Credentialing Committee or terminated from the network for cause are not eligible to reapply until five years after the date of termination. At the time of reapplication, Provider must meet all criteria for participation as outlined above.
30. Providers denied or terminated administratively are eligible to reapply for participation anytime as long as the Provider meets all criteria for participation above.

Burden of Proof

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

Provider termination and reinstatement

If a Provider’s contract is terminated and later it is determined to reinstate the Provider, the Provider must be initially credentialed prior to reinstatement if there is a break in service more than 30 calendar days. The credentialing factors that are no longer within the credentialing time limits and those that will not be effective at the time of the Credentialing Committee's review must be re-verified. The Credentialing Committee or medical director, as appropriate, must review all credentials and make a final determination prior to the Provider's reentry into the network. Not all elements require re-verification; for example, graduation from medical school or residency completion does not change. If the contract termination was administrative only and not for cause, if the break in service is less than 30 calendar days, the Provider can be reinstated without being initially credentialed.

If Molina Healthcare is unable to recredential a Provider within 36-months because the Provider is on active military assignment, maternity leave or sabbatical but the contract between Molina and the Provider remains in place, Molina Healthcare will recredential the Provider upon his or her return. Molina Healthcare will document the reason for the delay in the Provider’s file. At a minimum, Molina Healthcare will verify that a Provider who returns has a valid license to

practice before he or she can resume seeing patients. Within 60 calendar days of notice when the Provider resumes practice, Molina Healthcare will complete the recredentialing cycle. If either party terminates the contract and there is a break in service of more than 30 calendar days, Molina Healthcare will initially credential the Provider before the Provider rejoins the network.

Providers terminating with a delegate and contracting with Molina directly

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

Credentialing Application

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

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

Inability to perform essential functions and illegal drug use

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

History of actions against applicant

An application must contain the following information, unless State Law requires otherwise:

- History of loss of license;
- History of felony convictions and;
- History of all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which a Provider has had privileges.
- History of Medicare and Medicaid Sanctions

Current malpractice coverage

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

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

Correctness and completeness of the application

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

Meeting Application time limits

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

The Process for Making Credentialing Decisions

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

Molina recredentials its Providers at least every thirty-six (36) months. Approximately six months prior to the recredentialing due date, the Providers application will be downloaded from CAQH

(or a similar NCQA accepted online applications source), or a request will be sent to the Provider requesting completion of a recredentialing application.

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

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

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

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

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

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

Process for Delegating Credentialing and Recredentialing

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

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

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

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

Non-Discriminatory Credentialing and Recredentialing

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

Notification of Discrepancies in Credentialing Information

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

Notification of Credentialing Decisions

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

Confidentiality and Immunity

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

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

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

By providing patient care services at Molina, a Provider:

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

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

Any type of application or reapplication received by the Provider;

1. Actions reducing, suspending, terminating or revoking a Provider’s status, including requests for corrective actions, investigation reports and documents and all other information related to such action;
2. Hearing and appellate review;
3. Peer review and utilization and quality management activities;
4. Risk management activities and Claims review;
5. Potential or actual liability exposure issues;
6. Incident and/or investigative reports;
7. Claims review;
8. Minutes of all meetings by any committees otherwise appropriately appointed by the Board;

9. Any activities related to monitoring the quality, appropriateness or safety of health care services;
10. Minutes of any Committees and Subcommittees related to monitoring the quality, appropriateness or safety of health care services;
11. Any Molina operations and actions relating to Provider conduct.

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

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

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

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

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

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

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

Providers Rights during the Credentialing Process

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

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

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

Providers Right to Correct Erroneous Information

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

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

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

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

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

Credentialing Department will re-verify primary source information if such documentation is provided.

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

Providers Right to be Informed of Application Status

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

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

Credentialing Committee

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

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

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

Committee Composition

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

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

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

Committee Members Roles and Responsibilities

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

Excluded Practitioner Providers

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

Pursuant to section 1128 of the SSA, Molina Healthcare and its Subcontractors may not subcontract with an Excluded PractitionerProvider/Person. Molina Healthcare and its Subcontractors shall terminate subcontracts immediately when Molina Healthcare and its Subcontractors become aware of such excluded Provider/person or when Molina Healthcare and its Subcontractors receive notice. Molina Healthcare and its Subcontractors certify that neither it nor its member/Provider is presently debarred, suspended, proposed for debarment,

declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. Where Molina Healthcare and its Subcontractors are unable to certify any of the statements in this certification, Molina Healthcare and its Subcontractors shall attach a written explanation to this Agreement.

Ongoing Monitoring of Sanctions

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

Medicare Opt-Out

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

Medicare and Medicaid sanctions

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

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

Sanctions or limitations on licensure

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

NPDB Continuous Query (Proactive Disclosure Service)

Molina -enrolls all network Providers with the National Practitioner Data Bank ("NPDB") Continuous Query service.

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

Member Complaints/Grievances

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

Adverse Events

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

System for Award Management (SAM)

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

Medicare Opt-Out

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

Program Integrity (Disclosure of Ownership/Controlling Interest)

Medicaid Managed Care health plans are required to collect specific information from network Providers prior to contracting and during credentialing to ensure that it complies with Federal regulations that require monitoring of Federal and State sanctions and exclusions databases.

This monitoring ensures that any network Providers and the following details of any individual/entity being contracted and those individuals/entities affiliated with the contractor are appropriately screened against these sources, ensuring compliance with 42 CFR §455. The categorical details required and collected at all initial and recredentialing must be current and are as follows:

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

Office Site and Medical Record Keeping Practices Review

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

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

Range of Actions, Notification to Authorities and Provider Appeal Rights

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

Range of actions available

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

- Monitor on a Watch Status
- Require formal corrective action
- Denial of network participation
- Termination from network participation
- In cases where the Medical Director determines the circumstances pose an immediate risk to patients, a Provider may be summarily suspended from participation in the

network, without prior notice, pending review and investigation of information relevant to the case.

This applies to all Providers who are contracted by Molina. These actions do not apply to applicants who do not meet basic conditions of participation and are ineligible for participation. If at any point a Provider fails to meet the minimum standards and criteria for credentialing or fails to meet performance expectations with regard to quality of patient care the Credentialing Committee may act to implement one of these actions. Termination may be taken after reasonable effort has been made to obtain all the facts of the matter and the Provider may be given the opportunity to appeal this decision.

Criteria for Denial or Termination Decisions by the Credentialing Committee

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

1. The Provider's professional license in any State has or has ever had any informal or formal disciplinary orders, decisions, agreements, disciplinary actions or other actions including but not limited to, restrictions, probations, limitations, conditions suspensions and revocations.
2. Provider has or has ever surrendered, voluntarily or involuntarily, his or her professional license in any State while under investigation by the State or due to findings by the State resulting from the Provider's acts, omissions or conduct.
3. Provider has any pending statement of charges, notice of proposed disciplinary actions, notice of agency action or the equivalent from any State or governmental professional disciplinary body which based on the judgment of the Credentialing Committee establishes an immediate potential risk to the quality of care or service delivered by the Provider to Molina Members.
4. Provider has or has ever had any restrictions, probations, limitations, conditions, suspensions or revocations on their Federal Drug Enforcement Agency (DEA) certificate or Controlled Substance Certification or Registration.
5. Provider has a condition, restriction or limitation on their license, certification or registration related to an alcohol, chemical dependency, or health condition or if other evidence indicates that the Provider has an alcohol, chemical dependency problem or health condition and there is no clear evidence and documentation demonstrating that the Provider has complied with all such conditions, limitations, or restrictions and is receiving treatment adequate to ensure that the alcohol, chemical dependency problem or health condition will not affect the quality of the Provider's practice.
6. Provider has or has ever had sanctions of any nature taken by any Governmental Program or professional body including but not limited to, Medicare, Medicaid, Federal Employee Program or any other State or Federal program or agency.
7. Provider has or has ever had any denials, limitations, suspensions or terminations of participation of privileges by any health care institution, plan, facility or clinic.
8. Provider's history of medical malpractice claims or professional liability claims or settlements reflect what constitutes a pattern of questionable or inadequate treatment or contain what constitutes any gross or flagrant incident or incidents of malpractice.

9. Provider has a criminal history, including, but not limited to, any criminal charges, criminal investigations, convictions, no-contest pleas and guilty pleas.
10. Provider has or has ever had involvement in acts of dishonesty, fraud, deceit or misrepresentation that relate to or impact or could relate to or impact the Provider's professional conduct or the health, safety or welfare of Molina Members.
11. Provider has or has ever engaged in acts which Molina, in its sole discretion, deems inappropriate.
12. Provider has or has ever had a pattern of Member complaints or grievances in which there appears to be a concern regarding the quality of service provided to Molina Members.
13. Provider has not complied with Molina's quality assurance program.
14. Provider is found to have rendered a pattern of substandard care or is responsible for any gross or flagrant incident of substandard care.
15. Provider has or has ever displayed inappropriate patterns of referral, which deviate substantially from reasonably expected patterns of referral.
16. Provider makes or has ever made any material misstatements in or omissions from their credentialing application and attachments.
17. Provider has ever rendered services outside the scope of their license.
18. Provider has or has ever had a physical or mental health condition that may impair their ability to practice with the full scope of licensure and qualifications, or might pose a risk of harm on patients.
19. Provider has or has ever failed to comply with the Molina Medical Record Review Guidelines.
20. Provider has or has ever failed to comply with the Molina Site Review or Medical Record Keeping Practice Review Guidelines.

Monitoring on a Committee Watch Status

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

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

Corrective Action

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

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

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

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

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

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

Summary Suspension

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

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

- A description of the action being taken.

- Effective date of the action.
- The reason(s) for the action and/or information being investigated.
- Information (if any) required from the Provider.
- The length of the suspension.
- The estimated timeline for determining whether or not to reinstate or terminate the Provider.
- Details regarding the Providers right to request a fair hearing within 30 calendar days of receipt of the notice and their right to be represented by an attorney or another person of their choice (see Fair Hearing Plan policy).

- If the Provider does not request a fair hearing within the 30 calendar days, they have waived their rights to a hearing.
- The action will be reported to the NPDB if the suspension is in place longer than 30 calendar days.

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

Denial

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

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

Termination

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

Terminations for reasons other than unprofessional conduct or quality of care

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

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

Terminations based on unprofessional conduct or quality of care

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

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

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

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

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

Reporting to Appropriate Authorities

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

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

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

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

A letter is then written to the appropriate State licensing boards describing the adverse action taken, the Provider it was taken against and a copy of the NPDB report is attached to the letter.

This letter is sent certified to the appropriate State licensing boards within 24-hours of receiving the final NPDB report. A copy of this letter is filed into the Provider's credentials file. The action is also reported to other applicable State entities as required.

Fair Hearing Plan Policy

Under State and Federal Law, certain procedural rights shall be granted to a Provider in the event that peer review recommendations and actions require a report be made to the State Licensing Board and the National Practitioner Data Bank (NPDB).

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

A. Definitions

1. Adverse Action shall mean an action that entitles a Provider to a hearing, as set forth in Section B (l)-(3) below.
2. Chief Medical Officer shall mean the Chief Medical Officer for the respective Molina Affiliate State plan wherein the Provider is contracted.
3. Days shall mean calendar days. In computing any period of time prescribed or allowed by this Policy, the day of the act or event from which the designated period of time begins shall not be included.
4. Medical Director shall mean the Medical Director for the respective Molina Affiliate State plan wherein the Provider is contracted.
5. Molina Plan shall mean the respective Molina Affiliate State plan wherein the Provider is contracted.
6. Notice shall mean written notification sent by certified mail, return receipt requested, or personal delivery.
7. Peer Review Committee or Credentialing Committee shall mean a Molina Plan committee or the designee of such a committee.
8. Plan President shall mean the Plan President for the respective Molina Affiliate State plan wherein the Provider is contracted.
9. Provider shall mean physicians, dentists, and other health care Practitioners as defined by 42 USC 11151 and Social Security Act § 1861(u).
10. State shall mean the licensing board in the State in which the Provider practices.
11. State Licensing Board shall mean the State agency responsible for the licensure of Provider.
12. Unprofessional Conduct refers to a basis for corrective action or termination involving an aspect of a Provider's competence or professional conduct which is reasonably likely to be detrimental to patient safety or the delivery of quality care.

Unprofessional conduct does not refer to instances where a Provider violates a material term of the Provider's contract with a Molina Plan.

B. Grounds for a Hearing

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

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

C. Notice of Action

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

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

D. Request for a Hearing - Waiver

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

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

E. Appointment of a Hearing Committee

1. Composition of Hearing Committee

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

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

2. Scope of Authority

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

3. Responsibilities

The Hearing Committee shall:

a. Evaluate evidence and testimony presented.

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

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

4. Vacancies

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

5. Disclosure and Challenge Procedures

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

F. Hearing Officer

1. Selection

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

2. Scope of Authority

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

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

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

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

3. Responsibilities

The Hearing Officer shall:

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

b. Ensure that proper decorum is maintained;

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

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

e. Issue rulings on any objections or evidentiary matters;

f. Discretion to limit the amount of time;

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

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

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

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

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

l. Prepare the written report.

G. Time and Place of Hearing

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

H. Notice of Hearing

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

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

2. The name of the Hearing Officer.

3. The names of the Hearing Committee Members.

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

5. The names of witnesses, so far as they are then reasonably known or anticipated, who are expected to testify on behalf of the Peer Review Committee and/or Credentialing Committee, provided the list may be updated as necessary

and appropriate, but not later than ten (10) days prior to the commencement of the hearing.

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

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

I. Pre-Hearing Procedures

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

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

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

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

   To inspect and copy, at Molina's expense, any documents or other evidence relevant to the charges which the Provider has in his or her possession or control as soon as practicable after receiving the hearing request.

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

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

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

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

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

4. The Provider shall be entitled to a reasonable opportunity to question and object to or challenge the impartiality of members of the Hearing Committee and the

Hearing Officer. Challenges to the impartiality of any Hearing Committee member or the Hearing Officer shall be ruled on by the Hearing Officer.

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

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

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

J. Conduct of Hearing

1. Rights of the Parties

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

a. Call and examine witnesses for relevant testimony.

b. Introduce relevant exhibits or other documents.

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

d. Otherwise rebut evidence.

e. Have a record made of the proceedings.

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

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

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

2. Course of the Hearing

a. Each party may make an oral opening statement.

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

c. The affected Provider may then call any witnesses and present relevant documentary evidence supporting his/her defense.

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

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

3. Use of Exhibits

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

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

4. Witnesses

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

b. The Hearing Officer shall have the power to sequester witnesses (exclude any witness, other than a party or other essential person, during the testimony of any other witness). The names and addresses of all witnesses and a description of their testimony in the order received shall be made a part of the record.

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

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

5. Rules for Hearing:

a. Attendance at Hearings

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

b. Communication with Hearing Committee

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

c. Interpreter

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

K. Close of the Hearing

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

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

1. A summary of facts and circumstances giving rise to the hearing.
2. A description of the hearing, including:
    a. The panel members' names and specialties;
    b. The Hearing officer's name;
    c. The date of the hearing;
    d. The charges at issue; and
    e. An overview of witnesses heard and evidence.
3. The findings and recommendations of the Hearing Committee.
4. Any dissenting opinions desired to be expressed by the hearing panel members.

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

L. Burden of Proof

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

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

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

M. Provider Failure to Appear or Proceed

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

N. Record of the Hearing/Oath

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

O. Representation

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

P. Postponements

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

Q. Notification of Finding

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

R. Final Decision

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

S. Reporting

In the event the Chief Medical Officer/Plan President adopts the proposed decision of the Peer Review Committee and/or Credentialing Committee taking or recommending the

Adverse Action, Molina will submit a report to the State Licensing Board and the NPDB, as required. Reports shall be made in accordance with the Credentialing Program Policy.

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

T. Exhaustion of Internal Remedies

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

U. Confidentiality and Immunity

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

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

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

By providing patient care services at Molina, a Provider:

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

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

1. Any type of application or reapplication received by the Provider;

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

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

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

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

Section 11. Complaints, Grievance and Appeals Process

MEMBER GRIEVANCE AND APPEAL PROCESS

Molina Healthcare Members or Member's personal representatives have the right to file a grievance and/or submit an appeal through a formal process. This section addresses the identification, review and resolution of Member grievances and appeals. Below is Molina Healthcare's Member Grievance and Appeals Process.

GRIEVANCE PROCESS

"Grievance" means a verbal or written complaint submitted by or on behalf of a Member regarding service delivery issues other than denial of payment for or non-provision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or dissatisfaction with the service provided by Molina Healthcare.

You can file a grievance with your health plan if you are not happy with the way you were treated, the quality of care or services you received, you have problems getting care, or billing issues. You may file a Grievance, in writing, or by telephone. You must file Your Grievance within one hundred eighty (180) days from the day the incident or action occurred which caused you to be unhappy. If you need help filing a grievance, call Member Services at (888) 858-3492. To file a grievance contact:

Phone: (888) 858-3492

Molina Healthcare
Attention: Member Appeals
PO Box 4004
Bothell, WA 98041-4004

Fax: (877) 814-0342

Email: wamemberservices@molinahealthcare.com

Molina will keep your grievance private. We will let you know we received your grievance within 72 hours of the receipt our receipt of the request. We will resolve your grievance within 30 calendar days and tell you how it was resolved.

APPEAL PROCESS

An appeal is a request to review a denied service or referral or when you receive an Adverse Benefit Determination. You can appeal our decision if a service was denied, reduced or ended early due to an Adverse Benefit Determination.

"Adverse Benefit Determination" means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including a denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's or applicant's eligibility to participate in this plan, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Below are the two steps in the appeal process:

STEP 1: Molina Appeal (Internal Review)

STEP 2: Independent Review (External Review)

When the Internal Review or Appeal is final, you may request an External Review or Appeal of the Final Internal Adverse Benefit Determination.

Continuation of Services During the Appeal Process

If you are receiving services (or supplies) that are the subject of an Internal Review or Appeal, those services will be continued until the Internal Review or Appeal is resolved if you request the continuation. However, if Molina Healthcare prevails on final determination of the Internal Review or Appeal, you may be responsible for the cost of the coverage received during the review period. If you decide to pursue External Review of the appeal (with IRO) and if the IRO determines the service is Medically Necessary or appropriate for coverage under the Policy then Molina Healthcare will provide or pay for the health care service.

STEP 1 – Molina Appeal (Internal Review)

Requests for Internal Review or Appeal of Adverse Benefit Determinations must be received within 180 days of your receipt of an Adverse Benefit Determination. Requests for Internal Review or Appeals may be made by calling Molina Healthcare at 888-858-3492 between 7:30am to 6:30pm Monday through Friday excluding State holidays, or in writing and sent to the following mailing address, fax or electronic mail address:

Molina Healthcare
Attn: Grievance and Appeals Unit
P.O. Box 4004
Bothell, WA 98041

Fax: (877) 814-0342

Email: wamemberservices@molinahealthcare.com

You may choose someone, including an attorney or provider, to represent you and act on your behalf. You must sign a consent form allowing this person to represent you except in situations where the providers are seeking an expedited review (faster decision) of an adverse benefit determination on behalf of you the provider may act as your representative even if you have not formally notified the Molina of the designation. Molina Healthcare does not cover any fees or payments to your representatives. That is your responsibility.

We will send you a letter acknowledging receipt of your request for Internal Review or Appeal within 72 hours of our receipt of the request. Molina Healthcare's Internal Review or Appeal procedures will be completed within fourteen (14) calendar days for Adverse Benefit Determinations and twenty (20) calendar days for appeals involving Experimental and Investigational procedures. We may extend the time it takes to make a decision by up to 16 additional days if we notify you of the extension and the reason for the extension. Any further extensions by us are subject to your informed written consent to an extension and includes a

specific agreed-upon date for determination. An extension will not extend the time for a determination beyond thirty (30) calendar days without your written consent.

You may submit information, comments, records and other items to assist in the review. You may review and copy our records and information relevant to the claim free of charge. We will consider all information submitted prior to making our determination. Our review panel will be performed by persons who were not involved in the original decision and who are not subordinates of the persons who made the original decision.

After the Internal Review or Appeal is complete, We will send you a written decision on your appeal determination and will provide information about what we considered, including the clinical basis for our determination and how you can obtain the clinical review criteria used to help make the decision free of charge. If applicable, we will also provide you with information for obtaining an External Review or Appeal of a Final Internal Adverse Benefit Determination.

STEP 2 - Independent Review Organization (External Review)

If you disagree with Molina's appeal decision, you can ask for an External Review with Independent Review Organization. Within 180 days after you have received our Final Internal Adverse Benefit Appeal Determination, or if we have not responded to your request for an Internal Review or Appeal within the time periods noted above, you may request an External Review or Appeal from an Independent Review Organization ("IRO"). Requests for External Review or Appeals must be in writing and sent to the following mailing address, fax or electronic mail address:

Molina Healthcare
Attn: Grievance and Appeals Unit
P.O. Box 4004
Bothell, WA 98041

Fax: (877) 814-0342

Email: wamemberservices@molinahealthcare.com

Upon receipt of a valid request for an External Review or Appeal, Molina will arrange for the review from an Independent Review Organization (IRO) at no cost to you, and will provide you with the IRO contact information within 24 hours of selecting the IRO. The IRO is unbiased and not controlled by us. We will provide the IRO with the appeal documentation, but you may also provide them with information.

The IRO process is optional and you pay no application or processing fees of any kind. You have the right to give information in support of your request and have 5 business days from the request for an External Review or Appeal to submit any supporting written information to the IRO. If you are receiving services that are the subject of the appeal, those services will be continued until the matter is resolved by the IRO if you request the continuation. If our Adverse Benefit Determination is upheld by the IRO, you may be responsible for paying for any services that have been continued during the External Review or Appeal.

The dispute will be submitted to the IRO's medical reviewers who will make an independent determination of whether or not the care is Medically Necessary or appropriate and the application of this Policy's coverage provisions to your health care services. You will get a copy of the IRO's Final External Review Decision. If the IRO determines the service is Medically Necessary or appropriate for coverage under the Policy, Molina Healthcare will provide the health care service.

If your case involves Experimental or Investigational treatment, the IRO will ensure that adequate clinical and scientific experience and protocols are taken into account.

For non-urgent cases, the IRO must provide its determination within the earlier of fifteen (15) days after the IRO receives the necessary information or twenty (20) days of receipt of your request.

EXPEDITED REVIEW (FASTER DECISIONS)

REQUEST FOR INTERNAL EXPEDITED REVIEW

You may request an expedited Internal Review or Appeal of an Adverse Benefit Determination if one of the following conditions apply:

- You are currently receiving or have been prescribed treatment or benefits that would end because of the Adverse Determination.
- If your provider believes that a delay in treatment based on the standard review time may seriously jeopardize your life, overall health or ability to regain maximum function, or would subject you to severe and intolerable pain.
- If the Adverse Determination is related to an admission, availability of care, continued stay, or emergency health care services and You have not been discharged from the emergency room or transport service.

Requests for expedited Internal Reviews or Appeals may be made in writing or by telephone.

Providers seeking expedited review of an adverse benefit determination or a denied service or referral on behalf of a You may act as your representative even if you have not formally notified Molina Healthcare of the designation.

You, or a person designated by you to assist, or your provider may contact us by telephone or in writing at:

- **Call Molina Healthcare toll-free at (888) 858-3492, Monday through Friday, 7:30 am to 6:30 pm, excluding State holidays.**

- **Molina Healthcare**
  Grievance and Appeals Unit
  P.O. Box 4004
  Bothell, WA 98041

- **Email: wamemberservices@molinahealthcare.com**

Formal responses to an expedited Internal Review or Appeal will be issued preferably within twenty-four hours (24 hours), but in no case later than seventy-two hours (72 hours) after your initial contact with us.

REQUEST FOR EXTERNAL EXPEDITED REVIEW

You may request an expedited External Review or Appeal if one of the following conditions apply:

- You receive a Final Adverse Benefit Determination concerning an admission, availability of care, continued stay, or health care service for which you received emergency services and have not been discharged from the facility.
- You receive a Final Adverse Benefit Determination involving a medical condition for which the standard external review time would seriously jeopardize your life or health or jeopardize your ability to regain maximum function.
- Your request for a concurrent expedited review is granted.

If the External Review or Appeal is expedited, the IRO must notify you within 72 hours of its Final External Review Decision. If the notice is not in writing, the IRO must provide you with written confirmation of its Final External Review Decision within 48 hours after the date of the decision.

For more information regarding the External Review or Appeal process, or to request an appeal, please call Molina Healthcare toll-free at (888) 858-3492.

REQUEST FOR CONCURRENT EXPEDITED REVIEW

You may also request a concurrent expedited review of an Adverse Benefit Determination, which means that the Internal Review or Appeal and the External Review or Appeal are handled at the same time. Concurrent expedited reviews are available if one of the following conditions applies:

- You are currently receiving or have been prescribed treatment or benefits that would end because of the Adverse Determination.
- If your provider believes that a delay in treatment based on the standard review time may seriously jeopardize your life, overall health or ability to regain maximum function, or would subject you to severe and intolerable pain.
- If the Adverse Determination is related to an admission, availability of care, continued stay, or emergency health care services and you have not been discharged from the emergency room or transport service.

Requests for concurrent expedited review may be made in writing or by telephone. You, a person designated by you to assist, or your provider may contact us by telephone or in writing at:

- **Call Molina Healthcare toll-free at (888) 858-3492, Monday through Friday, 7:30 am - 6:30 pm, excluding State holidays.**

- **Molina Healthcare**
  Grievance and Appeals Unit
  P.O. Box 4004
  Bothell, WA 98041

- **Email: wamemberservices@molinahealthcare.com**

Molina Healthcare will issue a formal response preferably within twenty-four hours (24 hours), but in no case later than seventy-two hours (72 hours) after your initial contact with us.

Washington State Office of the Insurance Commissioner

If you have any questions or complaints regarding our handling of your Grievance or appeal, you may contact the Washington State Office of the Insurance Commissioner. A Washington State Office of the Insurance Commissioner representative will review your issues, and if the representative can't help you, he or she will point you in the right direction for further assistance.

Contact Information:

Consumer Protection Division
PO Box 40256
Olympia, WA 98504-0256

Call 800-562-6900 or
Call 360-725-7080
TDD 360-586-0241

Fax to 360-586-2018

Email CAP@oic.wa.gov

Record Retention

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

Provider Claims Dispute

In the event a Provider determines a claim has been improperly denied or underpaid, the Provider may make a written request for payment: (1) within 24 months after the date the claim was denied or payment intended to satisfy the claim was made; (2) within 30 months after the date the claim was denied or payment intended to satisfy the claim was made if the request is related to coordination of benefits with another carrier or entity responsible for payment of the claim. The Provider may not request payment be made any sooner than six months after Molina Healthcare's receipt of the request. Any request for review of denied or underpaid claims must be submitted to Molina Healthcare in accordance with the requirements stated in this section and conform to the following instructions:

The written request must:

- Specify why the Provider believes the services should be compensated or adjusted
- In the case of coordination of benefits, include the name and mailing address of any entity that has disclaimed responsibility for payment including EOB fi available
- Addressed to the attention of Molina Healthcare's Provider Services Department
- Include the claim number and or the authorization number if appropriate
- Clearly indicate "Denied Claims Review Request"
- Include all pertinent information including but not limited to, claim number, Member identifier, denial letter, supporting medical records and any new information pertinent to the request

Request for Denied Claims Review submitted without this documentation may be delayed. Denied Claim Review Requests submitted untimely from the original decision will be denied.

Request for denied claims review by Molina Healthcare should be e-mailed at MHWProviderServicesInternalRep@Molinahealthcare.com or mailed or faxed to:

- Molina Healthcare of Washington
  Attn: Provider Services
  PO Box 4004
  Bothell, WA 98041-4004

- Fax: (877) 814-0342

The Provider will be notified of Molina Healthcare's decision in writing within 60 days of receipt of the Denied Claims Review Request.

Section 12. Cultural Competency

Background

Molina Healthcare works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the US Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina strives to ensure the provision of Linguistic Access and Disability-related access to all Members, including those with limited English Proficiency.. Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds and religions as well as those with disabilities in a manner that recognizes values, affirms and respects the worth of the individuals and protects and preserves the dignity of each.

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

Provider and Community Training

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

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

1. Written materials;
2. On-site cultural competency training delivered by Provider Services Representatives;
3. Access to enduring reference materials available through Health Plan representatives and the Molina Healthcare website;
4. Integration of cultural competency concepts into Provider communications

Integrated Quality Improvement – Ensuring Access

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

Molina Healthcare provides oral interpreting of written information to any plan Member who speaks any non-English language regardless of whether that language meets the threshold of a prevalent non-English language. Molina Healthcare notifies plan Members of the availability of

oral interpreting services upon enrollment, and informs them how to access oral interpreting services at no cost to them.

Molina develops Member materials according to Plain Language Guidelines to accommodate Members with limited English proficiency or literacy skills. Members may also request written Member materials in alternate languages and formats, leading to better communication, understanding and Member satisfaction.

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

Program and Policy Review Guidelines

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

- Annual review of membership demographics (preferred language, ethnicity, race)
- Local geographic population demographics and trends derived from publicly available sources (Group Needs Assessment)
- Network Assessment
- Applicable national demographics and trends derived from publicly available sources
- Health status measures such as those measured by HEDIS, as available
- Comparison with selected measures such as those in Healthy People 2010
- Measures available through national testing programs such as the National Health and Nutrition Examination Survey (NHANES)

Linguistic Services

Molina serves a diverse population of Members with specific cultural needs and preferences. Providers are responsible for offering interpreter services at no cost for Members with sensory impairment and/or who have Limited English Proficiency (LEP). Molina Healthcare offers the following cultural and linguistic services to assist both Members and Providers.

Additional information on cultural and linguistic services is available at www.molinahealthcare.com and from your local Provider Services Representatives and the Molina Contact Center.

Section 13. Delegation

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

Delegation of Administrative Functions

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

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

Credentialing functions may be delegated to Capitated or Non-Capitated entities, which meet NCQA criteria for credentialing functions. Call Center, Claims Administration, Care Management and/or Utilization Management functions are generally only delegated to full risk entities. Non-Emergent Medical Transportation (NEMT) may be delegated to Vendors who can meet Call Center, Claims Administration and/or NMET requirements.

Note: The Molina Healthcare Member's ID card will identify which group the Member is assigned. If Claims Administration and/or UM has been delegated to the group, the ID card will show the delegated group's remit to address and phone number for referrals and prior authorizations. At this time Molina Healthcare of Washington does not delegate Call Center, Care Management or Claims Administration to the provider groups.

Delegation Criteria

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

Call Center

To be delegated for Call Center functions, Vendors must:

- Have a Vendor contract with Molina Healthcare (Molina does not delegate call center functions to IPAs or Provider Groups).
- Have a Call Center delegation pre-assessmentcompleted by Molina Healthcare to determine compliance with all applicable State and Federal regulatory requirements.
- Correct deficiencies within the timeframes identified in the correction action plan (CAP) when issues of non-compliance are identified by Molina Healthcare.
- Protect the confidentiality of all PHI as required by Law.
- Have processes in place to identify and investigate potential Fraud, Waste and Abuse.
- Must have an automated call system that allows the Vendor to confirm Member benefits and eligibility during the call.
- Agree to Molina Healthcare's contract terms and conditions for Call Center delegates.
- Submit timely and complete Call Center delegate reports as detailed in the delegation agreement and/or contract to the applicable Molina Healthcare contact.
- Current call center is able to demonstrate that service level performance for average speed to answer, abandonment rate, and percentage of calls that are complaints meet CMS and/or state requirements, depending on the line(s) of business delegated.

A Vendor may request Call Center delegation from Molina Healthcare through Molina Healthcare's Delegation Manager (or this process can be initiated by the Vendor's Contract Manager). Molina Healthcare will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate Call Center responsibilities is based on the vendor's ability to meet Molina Healthcare, State and Federal requirements for delegation.

Care Management

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

- Be certified by the National Committee for Quality Assurance (NCQA) for complex case management and disease management programs.
- Have a current complex case management and disease management program descriptions in place.
- Pass a care management pre assessment audit, based on NCQA and State requirements, and Molina Healthcare business needs.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina Healthcare.
- Agree to Molina Healthcare's contract terms and conditions for care management delegates.
- Submit timely and complete care management reports to Molina Healthcare.
- Comply with all applicable federal and state Laws.

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

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

assessment. The results of the pre-assessment are submitted to the DOC for review. Final decision to delegate the Complex Care Management and/or Disease Management process is based on the medical group/IPAs ability to meet Molina Healthcare's standards and criteria for delegation.

Claims Administration

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

- Have a capitation contract with Molina Healthcare and be in compliance with the financial reserves requirements of the contract.
- Be delegated for UM by Molina Healthcare.
- Protect the confidentiality of all PHI as required by Law.
- Have processes in place to identify and investigate potential Fraud, Wase, and Abuse.
- Have a Claims Administration delegation pre-assessment completed by Molina Healthcare to determine compliance with all applicable State and Federal regulatory requirements for Claims Administration.
- Correct deficiencies within timeframes identified in the correction action plan (CAP) when issues of non-compliance are identified by Molina Healthcare.
- Must have an automated system capable of providing Molina Healthcare with the Encounter Data required by the state in a format readable by Molina Healthcare.
- Agree to Molina Healthcare's contract terms and conditions for Claims Delegates.
- Submit timely and accurate delegation reports as detailed in the delegation agreement and/or contract to the applicable Molina Healthcare contact.
- Within (45) days of the end of the month in which care was rendered, provide Molina Healthcare with the Encounter Data required by the state in a format compliant with HIPAA requirements.
- Provide additional information as necessary to load Encounter Data within (30) days of Molina Healthcare's request.
- Comply with the standard Transactions and Code Sets requirements for accepting and sending electronic health care Claims information and remittance advice statements using the formats required by HIPAA.
- Comply with all applicable Federal and State Laws.
- When using Molina Healthcare's contract terms to pay for services rendered by Providers not contracted with IPA or group, follow Molina Healthcare's Claims Administration policies and guidelines, such as the retroactive authorization policy and guidelines for Claims adjustments and review of denied Claims.

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

Credentialing

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

- Pass Molina Healthcare's credentialing pre-assessment, which is based on NCQA credentialing standards, with a score of at least 90%
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina Healthcare
- Agree to Molina Healthcare's contract terms and conditions for credentialing delegates
- Submit timely and complete credentialing reports to Molina Healthcare
- Comply with all applicable federal and state Laws
- When key specialists, as defined by Molina Healthcare, contracted with IPA or group terminate, provide Molina Healthcare with a letter of termination according to Contractual Agreements and the information necessary to notify affected Members

Note: If the medical group/IPA is an NCQA Certified or Accredited organization, a modified pre-assessment audit will be conducted. Modification to the audit depend on the type of Certification or Accreditation the medical group/IPA has, but will always include evaluation of applicable state requirements and Molina Healthcare business needs.

If the medical group/IPA sub-delegates Credentialing functions, the sub-delegate must be NCQA accredited or certified in Credentialing functions, or demonstrate and ability to meet all Health Plan, NCQA, and State and Federal requirements identified above. Evaluation should be done prior to execution of a contract, and annually thereafter. Evaluation should include review of Credentialing policies and procedures, Credentialing and Recredentialing files, and a process to implement corrective action if issues of non-compliance are identified.

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

Non-Emergent Medical Transportation (NEMT)

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

- Have a Vendor contract with Molina Healthcare (Molina does not delegate NEMT functions to IPAs or Provider Groups).
- Pass Molina Healthcare's NEMT pre-assessment, which is based on State and Federal NEMT requirements.
- Have automated systems that allow for scheduling of NEMT appointments, confirmation of Member eligibility, and availability of NEMT benefits.

- Have processes in place to ensure protection of Member PHI.
- Have processes in place to identify and investigate potential Fraud, Waste, and Abuse.
- Have a network of vehicles and drivers that meet state and federal safety requirements.
- Ensure on at least an annual basis that vehicles continue to meet state and federal vehicle safety requirements.
- Ensure that drivers continually meet state and federal safety requirements.
- Have a process in place for reporting of all accidents, regardless of harm to Member, to Molina Healthcare within 48 hours.
- Agree to Molina Healthcare's contract terms and conditions for NEMT delegates, including applicable Call Center and/or Claims Administration delegation requirements.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina Healthcare.
- Submit timely and complete NEMT delegation reports to Molina Healthcare.
- Comply with all applicable federal and state Laws.

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

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

Utilization Management (UM)

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

- Have a UM program that has been operational at least one year prior to delegation
- Pass Molina Healthcare's UM pre-assessment, which is based on NCQA UM standards, with a score of at least 90%
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina Healthcare
- Agree to Molina Healthcare's contract terms and conditions for UM delegates
- Submit timely and complete UM delegate reports to Molina Healthcare
- Comply with the standard Transactions and Code Sets requirements for authorization requests and responses using the formats required by HIPAA
- Comply with all applicable federal and state Laws

Note: If the medical group/IPA is an NCQA Certified or Accredited organization, a modified pre-assessment audit will be conducted. Modifications to the audit depend on the type of

Certification or Accreditation the medical group/IPA has, but will always include evaluation of applicable state requirements and Molina Healthcare Business needs.

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

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

Quality Improvement/Preventive Health Activities

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

Delegation Reporting Requirements

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

Section 14. Glossary of Terms

Advanced Premium Tax Credit (APTC): a tax credit provided by the Federal government that can be used to cover monthly premiums for health coverage purchased through the marketplace. Tax credits are subject to income qualification criteria.

Affordable Care Act: the Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act of 2010, together with the Federal regulations implementing this Law and binding regulatory guidance issued by Federal regulators.

Annual Out-of-Pocket Maximum:

- **For Individuals** – is the maximum amount of Cost Sharing the Member, as an individual Member, will have to pay for Covered Services in a calendar year. The Cost Sharing and individual Annual Out-of-Pocket Maximum amounts applicable to the EOC are specified

in the Schedule of Benefits. For the EOC, Cost Sharing includes payments You make towards any Deductibles, Copayments or Coinsurance. Once the total Cost Sharing in a calendar year reaches the specified individual Annual Out-of-Pocket Maximum amount, Molina will pay 100% of the charges for Covered Services for the remainder of the calendar year. Amounts that the Member pays for services that are not Covered Services under the EOC will not count towards the individual Annual Out-of-Pocket Maximum.

- **For Family (2 or more Members)** – is the maximum amount of Cost Sharing that a family of two or more Members will have to pay for Covered Services in a calendar year. The Cost Sharing and family Annual Out-of-Pocket Maximum amounts applicable to the EOC are specified in the Schedule of Benefits. For the EOC, Cost Sharing includes payments the subscriber or other family members enrolled as Members under the EOC make towards any Deductibles, Copayments or Coinsurance. Once the total Cost Sharing made by two or more family members enrolled as Members under the EOC reaches the specified Annual Out-of-Pocket Maximum amount, Molina will pay 100% of the charges for Covered Services for all enrolled family Members for the remainder of the calendar year. Amounts that the subscriber or other family members enrolled as Members under the EOC pay for services that are not Covered Services under the EOC will not count towards the family Annual Out-of-Pocket Maximum.

Authorization or Authorized: a decision to approve specialty or other Medically Necessary care for a Member by the Member's PCP, medical group or Molina Healthcare. An Authorization is usually called an "approval."

Schedule of Benefits: (also referred to as "**Covered Services**") the healthcare services that Members are entitled to receive from Molina Healthcare under this Agreement.

Coinsurance: a percentage of the charges for Covered Services Members must pay when they receive Covered Services. The Coinsurance amount is calculated as a percentage of the rates that Molina Healthcare has negotiated with the Participating Provider. Coinsurances are listed in the Molina Healthcare Schedule of Benefits. Some Covered Services do not have Coinsurance and may apply a Deductible or Copayment.

Copayment: a specific dollar amount Members must pay when they receive Covered Services. Copayments are listed in the Molina Healthcare Schedule of Benefits. Some Covered Services do not have a Copayment, and may apply a Deductible or Coinsurance.

Cost Sharing: the Deductible, Copayment, or Coinsurance that Members must pay for Covered Services under this Agreement. The Cost Sharing amount Members will be required to pay for each type of Covered Service is listed in the Molina Healthcare Schedule of Benefits.

Deductible: is the amount You must pay in a calendar year for Covered Services You receive before Molina Healthcare will cover those services at the applicable Copayment or Coinsurance. The amount that You pay towards Your Deductible is based on the rates that Molina Healthcare has negotiated with the Participating Provider. Deductibles are listed in the Molina Healthcare of Washington Schedule of Benefits.

Please refer to the Molina Healthcare of Washington Benefits and Coverage Guide to see what Covered Services are subject to the Deductible and the Deductible amount. Your product may have separate Deductible amounts for specified Covered Services. If this is the case, amounts paid towards one type of Deductible cannot be used to satisfy a different type of Deductible.

When Molina Healthcare covers services at "no charge" subject to the Deductible and You have not met Your Deductible amount, You must pay the charges for the services. When preventive services covered by this Agreement are included in the Essential Health Benefits, You will not pay any Deductible or other Cost Sharing towards such preventive services.

There may be a Deductible listed for an individual Member and a Deductible for an entire family. If You are a Member in a family of two or more Members, You will meet the Deductible either:

i. when You meet the Deductible for the individual Member; or
ii. when Your family meets the Deductible for the family.

For example, if You reach the Deductible for the individual Member, You will pay the applicable Copayment or Coinsurance for Covered Services for the rest of the calendar year, but every other Member in Your family must continue to pay towards the Deductible until Your family meets the family Deductible

A "**Medical Deductible**" in the Silver and Gold Plans applies only to Outpatient Hospital or Facility and Inpatient Hospital or Facility services. It does not apply to outpatient professional services such as doctor office visits.

A "**Prescription Drug Deductible"** applies only to Formulary Non-Preferred Brand Name drugs and Specialty Drugs as described in the Prescription Drug Coverage benefit in the EOC.

When Molina Healthcare covers services at "no charge" subject to the Deductible and Members have not met their Deductible amount, the Member must pay the charges for the services. When preventive services covered by Molina are included in the Essential Health Benefits, Members will not pay any Deductible or other Cost Sharing towards those preventive services.

Dependent: a Member who meets the eligibility requirements as a Dependent, as described in the Evidence of Coverage.

Drug Formulary: is Molina Healthcare's list of approved drugs.

Durable Medical Equipment: is medical equipment that serves a repeated medical purpose and is intended for repeated use. It is generally not useful to Members in the absence of illness or injury and does not include accessories primarily for Member comfort or convenience.

Emergency or **Emergency Medical Condition:** the sudden onset of a medical, psychiatric or substance abuse condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or to a pregnancy in the case

of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Services: mean health care services needed to evaluate, stabilize or treat an Emergency Medical Condition.

Essential Health Benefits or "**EHB**"**:** a standardized set of essential health benefits that are required to be offered by Molina Healthcare to Members and their dependents, as determined by the Affordable Care Act. Essential Health Benefits covers at least the following 10 categories of benefits:

Ambulatory patient care

- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including dental* and vision care for Members under the age of 19

Experimental or Investigational: any medical service including procedures, medications, facilities, and devices that Molina Healthcare has determined have not been demonstrated as safe or effective compared with conventional medical services.

FDA: the United States Food and Drug Administration.

Habilitative Services: health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Care Facility: an institution providing health care services, including a hospital or other licensed inpatient center; an ambulatory surgical or treatment center; a skilled nursing center; a home health agency; a diagnostic, laboratory or imaging center; and a rehabilitation or other therapeutic health setting.

Marketplace: a governmental agency or non-profit entity that meets the applicable standards of the Affordable Care Act and helps residents of the State of Washington buy qualified health plan coverage from insurance companies or health plans. The Marketplace may be run as a State-based marketplace, a Federally-facilitated marketplace or a partnership marketplace. For the purposes of this document, the term refers to the Marketplace operating in the State of Washington however it may be organized and run.

Medically Necessary or **Medical Necessity:** health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate and clinically significant, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

Member: an individual who is eligible and enrolled under the EOC, and for whom Molina has received applicable Premiums. The term includes a Dependent and a Subscriber, unless the Subscriber is not applying for coverage on their own behalf, but is a responsible adult (the parent or legal guardian) who applies for Child-Only Coverage under the EOC on behalf of a minor child who, as of the beginning of the plan year, has not attained the age of 21, in which case the Subscriber will be responsible for making the Premium and Cost Sharing payments for the Member and will act as the legal representative of the Member under this product but will not be a Member.

Molina Healthcare of Washington, Inc. (Molina Healthcare or Molina): the corporation licensed by Washington as a Health Maintenance Organization, and contracted with the Marketplace.

Non-Participating Provider: refers to those physicians, hospitals, and other Providers that have not entered into contracts to provide Covered Services to Molina Marketplace Members.

Other Practitioner: refers to Participating Providers who provide Covered Services to Members within the scope of their license, but are not Primary Care Physicians or Specialist Physicians.

Participating Provider: refers to those Providers, including hospitals and physicians that have entered into contracts to provide Covered Services to Members through this product offered and sold through the Marketplace.

Premiums: mean periodic membership charges paid by or on behalf of each Member. Premiums are in addition to Cost Sharing.

Primary Care Doctor (also Primary Care Physician): the doctor who takes care of a Member's health care needs. A Primary Care Doctor may be one of the following types of doctors:

- Family or general practice doctors who usually can see the whole family.
- Internal medicine doctors, who usually only see adults and children 14 years or older.
- Pediatricians, who see children from newborn to age 18 or 21.
- Obstetricians and gynecologists (OB/GYNs).

Primary Care Provider or **"PCP":**

- a Primary Care Doctor, or
- an individual practice association (IPA) or group of licensed doctors which provides primary care services through the Primary Care Doctor.

Prior Authorization: means Molina's decision to approve specialty or other Medically Necessary care for a Member before services are provided. A Prior Authorization is sometimes called an "approval" or "authorization."

Service Area: the geographic area in Washington where Molina Healthcare has been authorized by the Office of the Insurance Commissioner to market individual products sold through the Marketplace, enroll Members obtaining coverage through the Marketplace and provide benefits through approved individual health plans sold through the Marketplace.

Specialist Physician: any licensed, board-certified, or board-eligible physician who practices a specialty and who has entered into a contract to deliver Covered Services to Members.

Spouse: the Subscriber's legal husband or wife.

Subscriber: an individual who is a resident of Washington, satisfies the eligibility requirements of this Agreement, is enrolled and accepted by Molina Healthcare as the Subscriber, and has maintained membership with Molina Healthcare.

Subscriber: means either:

1. An individual who is a resident of the plan State, satisfies the eligibility requirements of the EOC, is enrolled and accepted by Molina Healthcare as the Subscriber, and has maintained membership with Molina Healthcare in accordance with the terms of the EOC. This includes an individual who is not a minor and is applying on their own behalf for Child-Only Coverage under the EOC; or
2. A responsible adult (the parent or legal guardian) who applies for Child-Only Coverage under the EOC on behalf of a minor child, who as of the beginning of the plan year, has not attained the age of 21, in which case the Subscriber will be responsible for making the Premium and Cost Sharing payments for the Member, and will act as the legal representative of the Member under the EOC.

Urgent Care Services: those health care services needed to prevent the serious deterioration of one's health from an unforeseen medical condition or injury.