Provider Manual

Molina Healthcare of Arizona, Inc., An Arizona Corporation

Molina Complete Care

2022

The provider manual is customarily updated annually but may be updated more frequently as policies or regulatory requirements change. Providers can access the most current provider manual at www.MCCofAZ.com.

Last Updated: 03/2022

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1. INTRODUCTION

About Molina Complete Care

Molina Complete Care (MCC) is an integrated health plan designed for the total care of individuals, including medical and behavioral health needs. Our clinical and operational model of care (clinical, quality and population health programs) enables us to offer our members access to high-quality, clinically appropriate, affordable health care that's tailored to each individual's needs. Our ultimate goal is to improve health care outcomes and the overall quality of life for our members and their families.

MCC is part of Molina Healthcare, Inc., a health care management company that focuses on fast-growing, complex and high-cost areas of health care, with an emphasis on special population management.

MCC entered into a contract with the Arizona Health Care Cost Containment System (hereinafter referred to as "AHCCCS") for the provision of Medicaid managed care to individuals enrolled in the department's AHCCCS Complete Care program. Pursuant to the program requirements, MCC will provide the full scope of services and deliverables through an integrated and coordinated system of care as required, described and detailed herein, consistent with all applicable laws and regulations, and in compliance with service and delivery timelines as specified by AHCCCS and within the MCC clinical, quality and population health program documents.

MCC complies with AHCCCS and applicable federal requirements, in addition to applicable accreditation standards.

Model of Care

MCC delivers a fully integrated model of care (MOC) specially designed for members of the AHCCCS Complete Care program.

Our MOC functions as the foundation for improving the health status of Arizonians by using person-centered and population-based care management, which is delivered through Integrated Health Neighborhood (IHN) teams, to integrate community resources and non-traditional services within local health systems. We ensure that natural and peer supports, housing and employment are in place, in addition to traditional behavioral and medical treatment.

Our providers are the key to our success in delivering population-based, person-centered care. The level of support and coordination provided is dependent on each individual member's needs, which may be outlined within an individualized service plan (SP). MCC's interdisciplinary care team (ICT) is comprised of the member and/or a designated representative and individuals engaged in the member's life, who represent the continuum of physical and behavioral health and social delivery systems and is

based on their relationship and knowledge of the member. This ICT model ensures a collaborative approach to care management based on the level of service the member requires.

The composition of the ICT varies based on the member's needs and includes, at a minimum, the member or caregiver, primary and specialist providers, a care coordinator and/or care manager (CM) with both behavioral and physical health clinical expertise, peer support specialists, support staff care coordinators and a health guide. The health guide and support staff care coordinators help the member navigate the physical and behavioral health delivery systems and ensure the member receives all necessary behavioral and physical health services in order to live independently in the community.

MCC brings the same commitment to the provider community in Arizona as we have in other parts of the country for the last 25 years. Together, we can leverage our strength, experience and expertise to improve outcomes for individuals in need of comprehensive care.

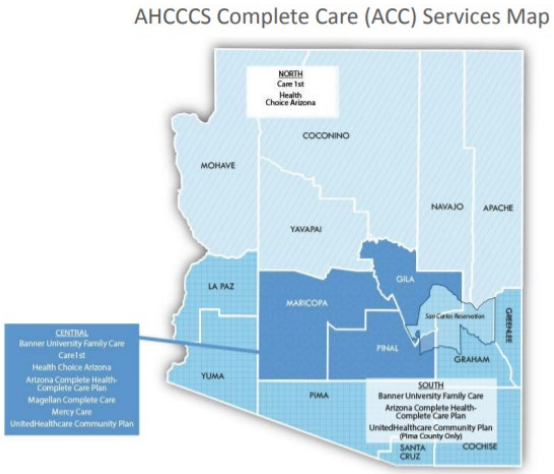
Integrated Health Neighborhood℠

MCC's goal to improve members' care and health outcomes can only be achieved within the context of where the members live—within their neighborhoods and communities. Our model builds an infrastructure with the health and social services system called the Integrated Health Neighborhood (IHN)℠, which customizes the delivery of care by region and supports and enhances the relationship between members and their providers.

Because our team members live and work within the communities where our members reside, these team members have firsthand knowledge of community strengths, resources, services and service gaps. IHN℠ team members include care coordinators and/or care managers, health guides, peer specialists and navigators and community outreach specialists supported by housing specialists, employment specialists, clinical pharmacists, medical directors and others.

The IHN℠ is MCC's mechanism to facilitate close collaboration with community partners, enhancing our ability to provide person-centered care to our members. This network naturally bridges language and cultural barriers, and more effectively and efficiently facilitates access to services to support our members and families where they live, work and play.

Molina Complete Care Service Area



2. CONTACT INFORMATION

Molina Complete Care
5055 E Washington St, Suite 210
Phoenix, AZ 85034

Provider Services

The provider services department handles telephone and written inquiries from providers regarding address and Tax-ID changes, contracting and training. The department has provider services representatives who serve all of MCC's provider network. Eligibility verifications can be conducted at your convenience via the provider portal.

Phone: (800) 424-5891
Fax: (888) 656-0369

Member Services

The Member Services department handles all telephone and written inquiries regarding member claims, benefits, eligibility/identification, pharmacy inquiries, selecting or changing primary care providers (PCPs) and member complaints. Member Services representatives are available Monday-Friday 8 a.m. to 6 p.m. MST, excluding state holidays. Eligibility verifications can be conducted at your convenience via the provider portal.

Phone: (800) 424-5891 (TTY/TDD: 711)

Claims

MCC strongly encourages participating providers to submit claims electronically (via a clearinghouse or provider portal) whenever possible.

- Access the provider portal (www.availity.com/molinacompletecare)
- EDI Payer ID MCC01

To verify the status of your claims, please use the provider Portal. For other claims questions, contact provider services.

Claims Recovery

The claims recovery department manages recovery for overpayment and incorrect payment of claims.

Molina Complete Care
5055 E Washington St, Suite 210
Phoenix, AZ 85034

Phone: (800) 424-5891

Compliance and Fraud AlertLine

If you suspect cases of fraud, waste, or abuse, you must report it to MCC. You may do so by contacting the Molina AlertLine or submitting an electronic complaint using the website listed below. For more information about fraud, waste and abuse, please see the compliance section of this provider manual.

Confidential
Compliance Official
Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802

Phone: (866) 606-3889
Website: MolinaHealthcare.alertline.com

Credentialing

The credentialing department verifies all information on the provider application prior to contracting and reverifies this information every three years, or sooner depending on MCC's Credentialing criteria. The information is then presented to the professional review committee to evaluate a provider's qualifications to participate in the MCC network.

Molina Complete Care
5055 E Washington St, Suite 210
Phoenix, AZ 85034

Phone: (800) 424-5891
Fax: (888) 656-0369

Nurse Advice Line

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

Phone: (800) 424-5891 (TTY/TDD: 711)

Health Care Services

The Health Care Services (HCS) Department combines Care Management (CM) and Utilization Management (UM) for an integrated model of care. UM conducts concurrent reviews on inpatient cases and processes prior authorizations and service requests. The HCS department also performs care management for members who will benefit from care management services. Participating providers are required to interact with MCC's HCS department electronically whenever possible. Prior authorizations, service requests and status checks can be easily managed electronically.

Managing prior authorizations and service requests electronically provides many benefits to providers, such as:

- Easy access to 24/7 online submission and status checks
- Ensuring HIPAA compliance
- The ability to receive real-time authorization status updates
- The ability to upload medical records
- Increased efficiencies through reduced telephonic interactions
- Reduced costs associated with fax and telephonic interactions

Providers can contact the HCS Department by calling (800) 424-5891.

You may also fax service requests and clinical to (888) 656-2201 for medical and behavioral Inpatient or (888) 656-7501 for medical and behavioral prior authorization service requests.

For Advanced Imaging requests you can call (855) 714-2415 or fax the request to (877) 731-7218.

MCC offers the following electronic prior authorizations and service requests submission options:

- Submit requests directly to MCC via the provider portal. See the provider portal quick reference guide or contact your provider services representative for registration and submission guidance.
- Submit requests via 278 transactions. See the EDI transaction section of MCC's website for guidance.

Provider portal: www.availity.com/molinacompletecare
Phone: (800) 424-5891
Fax: (888) 656-0369

Please see Health Care Services section under Provider Roles and Responsibilities for more information.

Health Management

MCC's health management programs will be incorporated into the member's treatment plan to address the member's health care needs.

Phone: (800) 424-5891
Fax: (888) 656-0369

Behavioral Health

MCC manages all components of covered services for behavioral health. For member behavioral health needs, please contact us directly at (800) 424-5891, 24 hours per day, 365 days per year.

Pharmacy

Prescription drugs are covered through CVS/Caremark. A list of in-network pharmacies are available at.www.MCCofAZ.com or by contacting MCC. Specialty Pharmacy requests covered under the medical benefit should also be directed to below:

Phone: (800) 424-5891
Fax: (844) 271-6887

Dental

Dental Service Authorization requests should be directed to DentaQuest.

Phone: (800) 424-5891
Fax: (262) 241-7150 -for non-hospital requests
Fax: (262) 834-3575 -for hospital and SPU requests

Quality Improvement

MCC maintains a quality department to work with members and providers in administering MCC's quality programs.

Phone: (800) 424-5891
Fax: (888) 656-0369

3. PROVIDER ROLES AND RESPONSIBILITIES

Non-discrimination of Health Care Service Delivery

Providers must comply with the nondiscrimination of health care service delivery requirements as outlined in the Cultural Competency and Linguistic Services section of this Provider Manual.

Additionally, MCC requires Providers to deliver services to MCC members without regard to source of payment. Specifically, Providers may not refuse to serve MCC members because they receive assistance with cost sharing from a government-funded program.

Section 1557 Investigations

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

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

Toll Free: (866) 606-3889
TTY/TDD: 711
Online: www.MolinaHealthcare.AlertLine.com
Email: civil.rights@MolinaHealthcare.com

Should you or an MCC member need more information, you can refer to the Health and Human Services website: www.federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority.

Facilities, Equipment and Personnel

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

Primary Care Provider Role

The primary care provider (PCP), with the support of the interdisciplinary care team (ICT), is responsible for the overall care of the member. This responsibility includes providing direct care, referring members for behavioral health, specialty or ancillary care

and coordinating care with the health plan and these providers for greater clinical outcomes.

A PCP must be:

- Currently licensed by the state of Arizona;
- A family practice, internal medicine, general practice, OB/GYN, or geriatrics practitioner; or
- A specialist who receives prior approval from MCC and performs primary care functions in locations that include, but aren't limited to, Federally Qualified Health Centers, Rural Health Clinics, Health Departments and other similar community clinics; and
- In good standing with the federal and federal/state Medicaid (AHCCCS) program.

Primary Care Provider Assignment for Non-Dual Eligible Members

MCC assigns all non-dual eligible members to a PCP at the date of the member's enrollment. Members may select a different in-network PCP at any time if they choose. When we call the member to schedule an initial assessment, we offer the member the opportunity to change their PCP assignment.

Our experience shows that members often require highly specialized primary care services to address their complex needs, along with related services and supports. We prioritize PCP assignment with Federally Qualified Health Centers and Integrated Clinics so members can receive primary care services at a location that best meets their needs.

Primary Care Provider Assignment for Dual Eligible Members

For dual eligible members, we utilize all AHCCCS and Medicare information provided to us to identify the member's PCP and enhance our care management efforts. We assist the member in finding or changing a PCP, including contacting the individual's Medicare health plan care manager when necessary.

We work with PCPs to coordinate care and invite the individual to participate in ICTs. We inform dual eligible members about their right to access Medicare providers, regardless of whether the provider is in our network, and without having to obtain prior approval.

Primary Care Provider Medication Management Services

PCPs may provide treatment for behavioral health conditions within the scope of their practice. PCPs who treat behavioral health conditions may provide medication management, including prescriptions, laboratory and other diagnostic tests necessary for diagnosis and treatment. Conversely, behavioral health providers may provide

physical health care services if, and when, they are licensed to do so within the scope of their practice.

Behavioral health providers are required to submit demographic data via online portal for demographics, social determinants and outcomes on the AHCCCS site at www.azahcccs.gov/PlansProviders/Demographics/.

MCC urges behavioral health providers to pay attention to communicating with the member's PCPs at the time of discharge from a behavioral health inpatient stay and/or whenever there's a significant change in the member's treatment plan, status or symptomology. We recommend faxing the discharge instruction sheet or a letter summarizing the hospital stay, including prescribed behavioral health medications, to the PCP. Any changes that may impact the member's treatment plan should be noted. The PCP is also encouraged to share changes in the treatment plan and summary of hospitalization with the behavioral health providers.

Fostering a culture of collaboration and cooperation helps maintain a seamless continuum of care between medical and behavioral health, and positively impacts member outcomes. If a member's medical or behavioral health condition or medication regimen changes, we expect that both PCPs and behavioral health providers will communicate those changes to each other. The ICT and CC and/or CM are available to help maintain continuity of care and coordination of members with complex needs by supporting communication between behavioral health and medical providers.

The Specialist Role

A specialist is any licensed provider providing specialty medical services to members. A PCP may refer a member to a specialist when medically necessary, including for behavioral health services (transition-aged youth, trauma, substance use in adolescents, opioid use disorder, supportive and rehabilitation services), Autism Spectrum Disorder, services for members birth to five, and social determinants of health needs . A PCP may communicate with a specialist directly to coordinate care, or a member may self-refer. If a PCP needs help finding a specialty provider for any area in the MCC network, they may contact MCC at (800) 424-5891 (TTY/TDD: 711) and request a care manager. Some services require a prior authorization. Specialists must obtain a prior authorization from MCC before performing specific procedures or when referring members to non-contracted providers.

Please refer to our website at www.MCCofAZ.com for services that require prior authorization. Providers can review prior authorization requirements in the summary of benefits or the evidence of coverage or by calling us at (800) 424-5891.

The specialist should:

- Communicate the member's condition and recommendations for treatment or follow-up with the PCP

- Include the following in the PCP communication: medical findings, test results assessments, treatment plan and any other pertinent information
- Understand that if a specialist needs to refer a member to another provider, the referral should be to another MCC participating provider
- Be aware that any referral to a non-participating provider will require a prior authorization from MCC

Specialist as the Primary Care Provider

With prior approval from MCC, a specialist may act as the PCP for a member. This role modification is often beneficial for members who have a life threatening, degenerative and/or disabling condition, or a disease requiring prolonged specialized medical care. The member's PCP is responsible for requesting a specialist to assume the PCP function. Such requests should be made to the utilization and/or care management department and must be approved by the medical director.

Provider Rights and Responsibilities

MCC is dedicated to selecting health care professionals, groups, agencies and facilities to provide member care and treatment across a range of covered services as defined by AHCCCS.

Network Provider Participation

To be a network provider of health care services with MCC under the AHCCCS Complete Care program, each provider must be credentialed and contracted according to MCC and AHCCCS standards. All providers are subject to applicable licensing requirements.

As an MCC network provider of health care services, each provider's responsibilities include:

1. Providing medically necessary covered services to members whose care is managed by MCC;
2. Following the policies and procedures outlined in this manual, any applicable supplements and the provider participation agreement(s) as well as AHCCCS policies and regulations;
3. Providing services in accordance with applicable state of Arizona and federal laws and licensing and certification bodies. Contracted providers for the AHCCCS Complete Care program network are required to abide by AHCCCS regulations and manuals and maintain active licensure for their contracted provider type and specialty at each service location. AHCCCS regulations and manuals can be found online at www.azahcccs.gov/PlansProviders/GuidesManualsPolicies/index.html;
4. Providing covered services to MCC members as outlined in this manual,

applicable supplements and provider agreement(s), as well as AHCCCS policies and regulations without exclusion or restriction on the basis of religious or moral objections.

5. Agreeing to cooperate and participate with all system of care management, quality improvement, outcomes measurement, peer review and appeal and grievance procedures;
6. Making sure only providers currently credentialed with MCC render services to MCC members; and
7. Following MCC's credentialing and recredentialing policies and procedures.

MCC's responsibility is to:

1. Offer assistance with a provider's administrative questions during normal business hours, Monday through Friday;
2. Not prohibit, or otherwise restrict health care providers acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the member's health status, medical care, or treatment options, including any alternative treatments that may be self-administered, any information the member may need in order to decide among all relevant treatment options, the risks, benefits and consequences of treatment or non-treatment, and not prohibit nor restrict the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
3. Assist providers in understanding and adhering to our policies and procedures, the payer's applicable policies and procedures and other requirements including but not limited to those of the National Committee for Quality Assurance (NCQA); and
4. Maintain a credentialing and recredentialing process to evaluate and select network providers that does not discriminate based on a member's benefit plan coverage, race, color, creed, religion, gender, sexual orientation, marital status, age, national origin, ancestry, citizenship, physical disability or other status protected by applicable law.

Provider Data Accuracy and Validation

It's important for providers to ensure MCC has accurate practice and business information. Accurate information allows us to better support and serve our members and provider network.

Maintaining an accurate and current provider directory is a state and federal regulatory requirement, as well as an NCQA required element. Invalid information can negatively impact member access to care, member and/or PCP assignments and referrals. Additionally, current information is critical for timely and accurate claims processing.

- Providers must validate the Provider Online Directory (POD) information at least quarterly for correctness and completeness. Providers must notify MCC in writing (some changes can be made online) as soon as possible, but no less than 30 calendar days in advance, of changes such as, but not limited to:

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

For Provider terminations (within an existing clinic/practice), Providers must notify MCC in writing in accordance with the terms specified in your Provider Agreement.

Please visit our Provider Online Directory at MolinaHealthcare.com to validate your information. For corrections and updates, a convenient Provider change form can be found on at https://www.molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/va/Forms/VA-ALL-PF-19268-21-NTWK-Prv-Data-Update-Form-FINAL_508c.aspx. You can also notify your Provider Services Representative or send an email to MCCAZ-Provider@molinahealthcare.com if your information needs to be updated or corrected.

Note: Some changes may impact credentialing. Providers are required to notify MCC of changes to credentialing information in accordance with the requirements outlined in the Credentialing and Recredentialing section of this Provider Manual.

MCC is required to audit and validate our provider network data and provider directories on a routine basis. As part of our validation efforts, we may reach out to our network of providers through various methods, such as:

- Letters
- Phone campaigns
- Face-to-face contact
- Fax and fax-back verification

MCC may also use a vendor to conduct routine outreach to validate data that impacts the provider directory or otherwise impacts its membership or ability to coordinate member care. Providers are required to supply timely responses to such communications.

National Plan and Provider Enumeration System Data Verification

CMS recommends that providers routinely verify and attest to the accuracy of their National Plan and Provider Enumeration System (NPPES) data.

NPPES allows providers to attest to the accuracy of their data. If the data is correct, the provider is able to attest and NPPES will reflect the attestation date. If the information isn't correct, the provider is able to request a change to the record and attest to the changed data, resulting in an updated certification date.

MCC supports the CMS recommendations around NPPES data verification and encourages our provider network to verify provider data online at www.nppes.cms.hhs.gov. Additional information regarding the use of NPPES is available in the frequently asked questions (FAQs) document published online at: www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.

MCC Electronic Solutions Participation

MCC requires providers to utilize electronic solutions and tools whenever possible.

MCC requires all contracted providers to participate in and comply with MCC's electronic solution requirements, which include, but aren't limited to, electronic submission of prior authorization requests, prior authorization status inquiries, health plan access to electronic medical records (EMR), electronic claims submission, electronic fund transfers (EFT), electronic remittance advice (ERA), electronic claims appeal and registration for and use of the provider portal.

Electronic claims include claims submitted via a clearinghouse using the EDI process and claims submitted through the provider portal.

Any provider entering the network as a contracted provider will be encouraged to comply with MCC's electronic solution policy by enrolling for EFT/ERA payments and registering for the provider portal within 30 days of entering the MCC network.

MCC is committed to complying with all HIPAA Transactions, Code Sets, and Identifiers (TCI) standards. Providers must comply with all HIPAA requirements when using electronic solutions with MCC. Providers must obtain an NPI and use their NPI in HIPAA transactions, including claims, submitted to MCC. Providers may obtain additional information by visiting MCC's HIPAA Resource Center located on our website at www.MCCofAZ.com.

Electronic Solutions and Tools Available to Providers

Electronic tools/solutions available to MCC providers include:

- Electronic claims submission options
- Electronic payment: EFT with ERA
- Provider portal

Electronic Claims Submission Requirement

MCC strongly encourages participating providers to submit claims electronically whenever possible. Electronic claims submission provides significant benefits to the provider such as:

- Promoting HIPAA compliance
- Helping to reduce operational costs associated with paper claims (printing, postage, etc.)
- Increasing accuracy of data and efficient information delivery
- Reducing claim processing delays as errors can be corrected and resubmitted electronically
- Eliminating mailing time and enabling claims to reach MCC faster

MCC offers the following electronic claims submission options:

- Submit claims directly to MCC via the provider portal. See our provider portal quick reference guide at www.provider.MolinaHealthcare.com or contact your provider services representative for registration and claim submission guidance
- Submit claims to MCC through your EDI clearinghouse using Payer ID MCC01. Refer to our website at www.MCCofAZ.com for additional information.

While both options are embraced by MCC, submitting claims via the provider portal (available to all providers at no cost) offers a number of additional claims processing benefits beyond the possible cost savings achieved from the reduction of high-cost paper claims.

Provider portal claims submission includes the ability to:

- Add attachments to claims
- Submit corrected claims
- Easily and quickly void claims
- Check claims status
- Receive timely notification of a change in status for a particular claim
- Ability to save incomplete/unsubmitted claims
- Create and/or manage claim templates

For more information on EDI claims submission, see the claims and compensation section of this provider manual.

Electronic Payment (EFT/ERA) Requirement

Participating providers are strongly encouraged to enroll in EFT and ERA. Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services give providers the ability to reduce paperwork, utilize searchable ERAs and receive payment and ERA access faster than the paper check and remittance advice (RA)

processes. There is no cost to the provider for EFT enrollment and providers aren't required to be in network to enroll. MCC uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery processes.

Additional instructions on how to register are available under the EDI/ERA/EFT tab on MCC's website at www.MCCofAZ.com.

Provider Portal

Providers and third-party billers can use the no-cost provider portal to perform many functions online without the need to call or fax MCC. Registration can be performed online, and once completed, the easy-to-use tool offers the following features:

- The ability to verify member eligibility, covered services and view HEDIS needed services (gaps)
- Claims:
  - Submit professional (CMS1500) and institutional (UB04) claims with attached files
  - Correct/void claims
  - Add attachments to previously submitted claims
  - Check claims status
  - View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP)
  - Create and manage claim templates
  - Create and submit a claim appeal with attached files
- Prior authorizations/service requests
  - Create and submit prior authorizations and/or service rRequests
  - Check status of prior authorizations and/or service requests
- View HEDIS® scores and compare to national benchmarks
- View a roster of assigned MCC members for PCPs
- Download forms and documents
- Send/receive secure messages to and from MCC

Balance Billing

The provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a member be liable to the provider for any sums that're the legal obligation of MCC to the provider. Balance billing an MCC member for covered services is prohibited, other than for the member's applicable copayment, coinsurance and deductible amounts.

Member Rights and Responsibilities

Providers are required to comply with the member rights and responsibilities as outlined in MCC's member materials (such as member handbooks).

For additional information please refer to the member rights and responsibilities section in this provider manual.

Member Information and Marketing

Any written informational or marketing materials directed to MCC members must be developed and distributed in a manner compliant with all state and federal laws and regulations and approved by MCC prior to use.

Please contact your provider services representative for information and review of proposed materials.

Member Eligibility Verification

Possession of an MCC ID card doesn't guarantee member eligibility or coverage. Providers should verify eligibility of MCC members prior to rendering services. Payment for services rendered is based on enrollment and benefit eligibility. The contractual agreement between providers and MCC places the responsibility for eligibility verification on the provider of services.

For additional information, please refer to the member eligibility, enrollment and disenrollment section of this provider manual.

Member Cost Share

Providers should verify the MCC member's cost share status prior to requiring the member to pay copay, coinsurance, deductible or other cost share that may be applicable to the member's specific benefit plan. Some plans have a total maximum cost share that frees the member from any further out of pocket charges once reached (during that calendar year).

Health Care Services (Utilization Management and Care Management)

Providers are required to participate in and comply with MCC's utilization management and care management programs, including all policies and procedures regarding MCC's facility admission, prior authorization, concurrent and medical necessity review determination and ICT procedures. Providers will also cooperate with MCC in audits to identify, confirm and/or assess utilization levels of covered services.

Utilization Management

The purpose of the MCC utilization management program is to support optimal use of health care services and supports for the evaluation, treatment and integration of medical, dental and behavioral health conditions. The MCC utilization management and care management teams collaborate to ensure seamless, timely and accurate care and service authorization processes.

The program meets its objectives in part by conducting prospective, concurrent, retrospective and discharge planning review of services rendered to its members. The utilization department monitors quality, continuity and coordination of care as well as overutilization/underutilization and medical necessity of services. High risk/high cost cases are followed closely by the HCS staff to ensure that the most cost-effective services are identified, coordinated, implemented and evaluated on a continual basis. Services provided aren't less than the amount, duration and scope for the same services delivered to fee-for-service (FFS) Medicaid members. Medically necessary services aren't more restrictive than used in the state-defined program. MCC makes the utilization management criteria available in writing, by mail, or fax for providers and members or members. MCC supports continuity and coordination of care for physical, dental and behavioral health providers.

Providers can call our toll-free number at (800) 424-5891 with any utilization management questions.

- Our MCC team members are available for incoming calls Monday-Friday 8 a.m. to 6 p.m. MST
- Our MCC team members can receive incoming calls regarding utilization management concerns after normal business hours
- Our MCC team members can send out communications regarding questions during normal business hours, unless otherwise agreed upon
- Our MCC team members are available to accept collect calls
- Our MCC team members will identify themselves by name, title and our organization name of MCC when initiating or returning calls
- Our MCC team members are available to callers who have questions about the utilization management processes
- A utilization management dedicated fax line and electronic portal can be used to submit requests for medical necessity determinations 24 hours a day/7 days a week
- An after-hours, on-call nurse is available for emergent and/or urgent concerns

In addition, the Health Care Services Department is charged with developing, implementing and continuously monitoring the Medical Management Work Plans. The utilization management team collaborates with the care management and health services teams to ensure that all work plans are coordinated between departments. The Medical Management program generates policy and procedures and provides general direction and guidance toward policy execution. The Medical Management Committee and the Quality Improvement Committee (QIC) work together to ensure the health and well-being of individuals enrolled in MCC. This is achieved through the development and administration of health care benefits and health case coordination processes that facilitate the availability and accessibility of services in accordance with corporate policies, federal, state and local regulations and accreditation standards.

For additional information and additional Provider Roles and Responsibilities please refer to the Health Care Services section of this Provider Manual.

In-Office Laboratory Tests

MCC's policies allow only certain lab tests to be performed in a provider's office regardless of the line of business. All other lab testing must be referred to an in-network laboratory provider that is a certified, full-service laboratory, offering a comprehensive test menu that includes routine, complex, drug, genetic testing and pathology. A list of those lab services that are allowed to be performed in the provider's office is found online at www.MCCofAZ.com.

Additional information regarding in-network laboratory providers and in-network laboratory provider patient service centers can be found on the laboratory providers' respective websites at www.appointment.questdiagnostics.com/patient/confirmation and www.labcorp.com/labs-and-appointments.

Specimen collection is allowed in a provider's office and shall be compensated in accordance with your agreement with MCC and applicable state and federal billing and payment rules and regulations.

Claims for tests performed in the provider's office, but not on MCC's list of allowed in-office laboratory tests will be denied.

Referrals

A referral may become necessary when a provider determines medically necessary services are beyond the scope of the PCP's practice, or it's necessary to consult or obtain services from other in-network specialty health professionals, unless the situation is one involving the delivery of emergency services. Information is to be exchanged between the PCP and specialist to coordinate care of the patient to ensure continuity of care. Providers need to document referrals that are made in the patient's medical

record. Documentation needs to include the specialty, services requested and diagnosis for which the referral is being made.

Providers should direct MCC members to health professionals, hospitals, laboratories and other facilities and providers which are contracted and credentialed (if applicable) with MCC. In the case of urgent and emergency services, providers may direct members to an appropriate service including, but not limited to:

- Primary care
- Urgent care
- Hospital emergency room

There may be circumstances in which referrals may require an out-of-network provider. Prior authorization will be required from MCC except in the case of emergency services.

For additional information, please refer to the health care services section of this provider manual.

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

Treatment Alternatives and Communication with Members

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

Pharmacy

Providers are required to adhere to MCC's drug formularies and prescription policies. For additional information, please refer to the covered pharmacy services section of this provider manual.

Participation in Quality Programs

Providers are expected to participate in MCC's quality programs and collaborate with MCC in conducting peer review and audits of care rendered by providers. Such participation includes, but is not limited to:

- Access to care standards
- Site and medical recordkeeping practice reviews, as applicable
- Delivery of patient care information

For additional information, please refer to the quality section of this Provider Manual.

Compliance

Providers must comply with all state and federal laws and regulations related to the care and management of MCC members.

Confidentiality of Member Health Information and HIPAA Transactions

MCC requires that providers respect the privacy of MCC members (including MCC members who aren't patients of the provider) and comply with all applicable laws and regulations regarding the privacy of patient and member PHI. For additional information, please refer to the compliance section of this provider manual.

Participation in Grievance and Appeals Programs

Providers are required to participate in MCC's grievance program and cooperate with MCC in identifying, processing and promptly resolving all member complaints, grievances, or inquiries. If a member has a complaint regarding a provider, the provider will participate in the investigation of the grievance. If a member submits an appeal, the provider will participate by providing medical records or statements if needed. This includes the maintenance and retention of member records for a period of no less than 10 years and retained further if the records are under review or audit until such time that the review or audit is complete.

For additional information, please refer to the member grievances and appeals section of this provider manual.

Participation in Credentialing

Providers are required to participate in MCC's credentialing and recredentialing process and will satisfy, throughout the term of their contract, all credentialing and recredentialing criteria established by MCC and applicable accreditation, state and federal requirements. This includes providing prompt responses to MCC's requests for information related to the credentialing or recredentialing process.

Providers must notify MCC no less than 30 days in advance when they relocate or open an additional office.

More information about MCC's credentialing program, including policies and procedures is available in the credentialing and recredentialing section of this provider manual.

Delegation

Delegated entities must comply with the terms and conditions outlined in MCC's delegation policies and delegated services addendum. Please see the delegation section of this provider manual for more information about MCC's delegation requirements and delegation oversight.

Primary Care Provider Responsibilities

PCPs are responsible to:

- Serve as the ongoing source of primary and preventive care for Members
- Assist with coordination of care as appropriate for the Member's health care needs
- Recommend referrals to specialists participating with MCC
- Triage appropriately
- Notify MCC of Members who may benefit from Care Management
- Participate in the development of Care Management treatment plans

4. CULTURAL COMPETENCY AND LINGUISTIC SERVICES

Background

MCC 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 U.S. Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. MCC complies with Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA) Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) and other regulatory/contract requirements. Compliance ensures the provision of linguistic access and disability-related access to all members, including those with Limited English Proficiency (LEP) and members who are deaf, hard of hearing, non-verbal, have a speech impairment, or have an intellectual disability. Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds, genders, gender identities, sexual orientations, ages and religions, as well as those with disabilities in a manner that recognizes values, affirms and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on cultural competency and linguistic services is available at www.MCCofAZ.com, from your local provider services representative and by calling MCC at (800) 424-5891.

Non-discrimination of Health Care Service Delivery

MCC complies with the guidance set forth in the final rule for Section 1557 of the ACA, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all MCC website home pages. All Providers who join the MCC Provider Network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS), the Office for Civil Rights (OCR), State law, and Federal program rules which prohibit discrimination. Providers must post a non-discrimination notification in a conspicuous location in their office along with translated non-English taglines in the top languages spoken in the State to ensure MCC members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred. For additional information, please refer to the Member Handbook located at https://www.molinahealthcare.com/members/az/en-us/mem/medicaid/member-materials-and-forms.aspx.

Additionally, participating providers or contracted medical groups/Independent Physician Associations (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.

Providers can refer MCC members who're complaining of discrimination to the Molina Civil Rights Coordinator at: (866) 606-3889, or TTY/TDD: 711.

Members can also email the complaint to civil.rights@MolinaHealthcare.com.

Members can mail their complaint to Molina at:

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

Members can also file a civil rights complaint with the U.S. Department of Health and Human Services, OCR. Complaint forms are available at: www.hhs.gov/ocr/complaints/index.html.

The form can be mailed to:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Members can also send it to a website through the Office for Civil Rights Complaint Portal at www.ocrportal.hhs.gov/ocr/portal/lobby.jsf.

If you or an MCC member needs help, call (800) 368-1019 or TTY/TDD: (800) 537-7697.

Should you or an MCC member need more information, you can refer to the Health and Human Services website at: www.federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority.

Cultural Competency

MCC is committed to reducing health care disparities. Training employees, providers and their staff, and quality monitoring are the cornerstones of successful culturally competent service delivery. MCC integrates cultural competency training into the overall provider training and quality monitoring programs. An integrated quality approach enhances the way people think about our members, service delivery and program development so that cultural competency becomes a part of everyday thinking.

MCC staff are trained in cultural diversity and sensitivity to support our interactions with members, and refer members to providers that're appropriate to their needs and preferences. MCC provides cultural competency training, technical assistance and online resources to help providers enhance their provision of high-quality, culturally appropriate services.

MCC provides interpreter access for members from culturally and linguistically diverse backgrounds, and for people with hearing, speech and communication impairments. Interpreter services for all languages, including sign language, are provided at no cost to our members. MCC facilitates language assistance provided to LEP members, including how to work with interpreters and telephone language services or working with translated written materials. Members, or providers on behalf of a member, can schedule an on-site interpreter by calling MCC at (800) 424-5891 to request interpretation services.

MCC's telephone language line available 24 hours a day, 7 days a week. Participants who are hearing impaired or have speech impairment have access to the TTY/TDD service line by calling TTY/TDD: 711. Participants who don't have TTY/TDD can communicate with a TTY/TDD user through Message Relay Center (MRC). MRC has TTY/TDD operators available to send and interpret TTY/TDD messages.

MCC continually assesses network composition by actively recruiting, developing, retraining and monitoring a diverse provider network compatible with the member population.

We depend on our providers to:

1. Provide MCC with information on languages spoken by the provider or the provider's staff.
2. Provide MCC with any practice specialty information the provider holds on the provider credentialing application.
3. Provide oral and American Sign Language (ASL) interpretation services. In accordance with Title VI of the Civil Rights Act, Prohibition against National Origin Discrimination, providers must make oral interpretation services available to persons with (LEP) at all points of contact. Oral interpretation services are provided at no cost to members. Members must be provided with information instructing them on how to access these services. Interpretation services are the facilitation of oral or sign language communication, either simultaneously or consecutively, between users of different languages.
4. Translate any documents that require the signature of the member and that contains vital information regarding treatment, medications, or service plans into their preferred and/or primary language if requested by the member or his/her guardian.
5. Inform us if the provider objects to the provision of any counseling, treatments or referral services on religious grounds.

MCC's responsibility is to:

1. Provide ongoing education to help providers deliver culturally informed services to people of all cultures, races, ethnic backgrounds, religions and those members with disabilities.
2. Provide language assistance, including bilingual staff and interpreter services, to those with LEP during all hours of operation at no cost to the member.
3. Assist providers in locating interpreters for our members when requested by the member or when requested by the provider.
4. Provide easily understood member materials, available in the languages of the commonly encountered groups and/or groups represented in the service area.
5. Monitor gaps in services and other culturally specific provider service needs. When gaps are identified, MCC will develop a provider recruitment plan and monitor its effectiveness.

Provider and Community Training

MCC offers educational opportunities in cultural competency concepts for providers, their staff and community-based organizations (CBOs). MCC conducts provider training during provider orientation with annual reinforcement training offered through provider services and/or online/web-based training modules.

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

1. Provider written communications and resource materials
2. On-site cultural competency training
3. Online cultural competency provider training modules
4. Integration of cultural competency concepts and non-discrimination of service delivery into provider communications

Integrated Quality Improvement – Ensuring Access

MCC ensures member access to language services such as oral interpretation, ASL and written translation. MCC must also ensure access to programs, aids and services that are congruent with cultural norms. MCC supports members with disabilities and assists members with LEP.

MCC develops member materials according to plain language guidelines. Members or providers may also request written member materials in alternate languages and formats (i.e., Braille, audio, large format), leading to better communication, understanding and member satisfaction. Online materials and information delivered in digital form meet Section 508 accessibility requirements to support members with visual impairments.

Key member information, including appeal and grievance forms, are also available in threshold languages on the MCC member website.

Program and Policy Review Guidelines

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

- Annual collection and analysis of race, ethnicity and language data from:
  - Eligible individuals to identify significant culturally and linguistically diverse populations within a plan's membership
  - Contracted providers to assess gaps in network demographics
- Revalidate data at least annually
- Local geographic population demographics and trends derived from publicly available sources (community health measures and state rankings report)
- Applicable national demographics and trends derived from publicly available sources
- Assessment of provider network
- Collection of data and reporting for the Diversity of Membership HEDIS® measure
- Annual determination of threshold languages and processes in place to provide members with vital information in threshold languages
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations
- Analysis of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience survey results for potential cultural and linguistic disparities that prevent members from obtaining the recommended key chronic and preventive services

Access to Interpreter Services

MCC providers must support member access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset. Providers may offer MCC members interpreter services if the members don't request them on their own. Please remember it's never permissible to ask a family member, friend or minor to interpret.

Documentation

As a contracted MCC provider, your responsibilities for documenting member language services and/or needs in the member's medical record are as follows:

- Record the member's language preference in a prominent location in the medical record. This information is provided to you on the electronic member lists that are sent to you each month by MCC.
- Document all member requests for interpreter services.
- Document who provided the interpreter service. This includes the name of MCC's internal staff or someone from a commercial interpreter service vendor. Information should include the interpreter's name, operator code and vendor.
- Document all counseling and treatment done using interpreter services.

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

Members Who Are Deaf or Hard of Hearing

MCC provides a TTY/TDD connection accessible by dialing 711. This connection provides access to the member and provider contact center, quality, health care services and all other health plan functions.

MCC strongly recommends that provider offices make assistive listening devices available for members who are deaf and hard of hearing. Assistive listening devices enhance the sound of the provider's voice to facilitate a better interaction with the member.

MCC will provide face-to-face service delivery for ASL to support our members who're deaf or hard of hearing. Requests should be made three business days in advance of an appointment to ensure availability of the service. In most cases, members will have made this request via Member Services.

The provider must ensure that the programs and services are as accessible (including physical and geographic access) to individuals with disabilities as they are to individuals without disabilities. Specifically, providers shall comply with the ADA (28 CFR § 35.130) and Section 504 of the Rehabilitation Act of 1973 (29 USC § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its members by:

1. Providing flexibility in scheduling to accommodate the needs of members;
2. Providing interpreters or translators for members who are deaf and hard of hearing and those who do not speak English;
3. Ensuring that individuals with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the individual, and include but are not limited to:
    a. Ensuring safe and appropriate physical access to buildings, services and equipment;
    b. Ensuring providers allow extra time for members to dress and undress, transfer to examination tables and extra time with the practitioner in order to ensure that the individual is fully participating and understands the information

Nurse Advice Line

MCC provides nurse advice services for members 24 hours per day, 7 days per week. The Nurse Advice Line provides access to 24hour interpretive services. Members may call MCC's Nurse Advice Line directly at (800) 424-5891 (TTY/TDD: 711). The Nurse Advice Line telephone numbers are also printed on membership cards.

5. MEMBER RIGHTS AND RESPONSIBILITIES

Providers must comply with the rights and responsibilities of MCC members as outlined in the MCC member handbook and on the MCC website. The member handbook that is provided to members annually is hereby incorporated into this provider manual. The most current member rights and responsibilities can be accessed via the following link: www.molinahealthcare.com/members/az/en-us/mem/medicaid/member-materials-and-forms.aspx.

Member handbooks are available on MCC's member website. Member rights and responsibilities are outlined under the heading "Your Rights and Responsibilities" within the member handbook document, which can be accessed via the following link: www.molinahealthcare.com/members/az/en-us/mem/medicaid/quality/rights.aspx.

State and federal law requires that health care providers and health care facilities recognize member rights while the members 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 the members.

For additional information, please contact MCC at (800) 424-5891 (TTY/TDD: 711) Monday- Friday, 8 a.m. to 6 p.m. MST.

Second Opinions

If members don't agree with their provider's plan of care, they have the right to a second opinion from another provider. Members should call Member Services to find out how to get a second opinion. Second opinions may require prior authorization.

6. MEMBER ELIGIBILITY, ENROLLMENT, DISENROLLMENT

Enrollment

Enrollment in Medicaid Programs

The AHCCCS Complete Care program provides integrated care addressing physical health and behavioral health needs for the following Title XIX/XXI populations:

1. Adults who aren't determined to have a Serious Mental Illness excluding DES/DDD enrolled members,
2. Children, including those with special health care needs; excluding DES/DDD and DCS/CMDP enrolled members, and
3. Members determined to have SMI who opt to transfer to the Contractor for the provision of physical health services as outlined in ACOM Policy 442.

Eligibility Groups

The AHCCCS Complete Care program is made up of multiple groups, each with distinct eligibility and/or enrollment requirements and benefits:

Title XIX

1. Parents/caretaker relatives: Eligible individuals under the 1931 provision of the Social Security Act, with income at or below 106% of the FPL.
2. Supplemental security income (SSI) cash: Eligible individuals receiving SSI through federal cash assistance programs under Title XVI of the Social Security Act who are aged, blind or who have a disability and have income at or below 100 percent of the federal benefit rate (FBR).
3. SSI medical assistance only (SSI MAO) and related groups: Eligible individuals who are aged, blind or who have a disability and have household income levels at or below 100% of the FPL.
4. Freedom to work (ticket to work): Eligible individuals under the Title XIX program that extends eligibility to individuals 16 through 64 years old who meet SSI disability criteria, and whose earned income after allowable deductions is at or below 250% of the FPL and who aren’t eligible for any other Medicaid program. These members must pay a premium to AHCCCS, depending on income.
5. Pregnant women: Eligible pregnant women, with income at or below 156% of the FPL,
6. Children: Eligible children with incomes ranging from below 133% to 147% of the FPL, depending on the age of the child.
7. Breast and cervical cancer treatment program (BCCTP): Eligible individuals under the Title XIX expansion program for women with incomes at or below 250% of the FPL who are diagnosed with and need treatment for breast and/or

cervical cancer or cervical lesions, and are't eligible for other Title XIX programs. Eligible members can't have other creditable health insurance coverage, including Medicare.

8. Title IV-E foster care and adoption subsidy: Children who are in state foster care or are receiving federally funded adoption subsidy payments.
9. Young adult transitional insurance (YATI): Transitional medical care for individuals age 18 through age 25 who were enrolled in the foster care program under jurisdiction of the Department of Child Safety in Arizona on their 18th birthday.
10. Adult group at or below 106% FPL: Adults aged 19-64 without Medicare, with income at or below 106% of the FPL (Adults </= 106%).
11. Adult group above 106% FPL: Adults aged 19-64 without Medicare, with income above 106% through 133% of the FPL (Adults > 106%).

Title XXI

1. ***KidsCare***: Federal and State Children's Health Insurance program (Title XXI – CHIP) administered by AHCCCS. The KidsCare program offers comprehensive medical, preventive, treatment services and behavioral health care services statewide to eligible children under the age of 19 in households with income between 133% and 200% of the FPL.

State-Only Transplants

1. Working directly with an MCC designated transplant coordinator, Title XIX individuals, for whom medical necessity for a transplant has been established and who subsequently lose Title XIX eligibility under a category other than adult group, may become eligible for and select one of two extended eligibility options as specified in A.R.S. §36-2907.10 and A.R.S. §36-2907.11. The extended eligibility is authorized only for those individuals who have met all of the following conditions:

    - The individual has been determined ineligible for Title XIX due to excess income,
    - The individual had been placed on a donor wait list before eligibility expired, and
    - The individual has entered into a contractual arrangement with the transplant facility to pay the amount of income which is in excess of the eligibility income standards (referred to as transplant share of cost).

2. The following options for extended eligibility are available to these members:

    - Option one: Extended eligibility is for one 12-month period immediately following the loss of AHCCCS eligibility. The member is eligible for all AHCCCS covered services as long as they continue to be medically eligible for a transplant. If determined medically ineligible for a transplant at any time

during the period, eligibility will terminate at the end of the calendar month in which the determination is made.
- Option two: The member loses AHCCCS eligibility but maintains transplant candidacy status as long as medical eligibility for a transplant is maintained. At the time the transplant is scheduled to be performed, the transplant candidate will reapply and will be re-enrolled with his/her previous Contractor to receive all covered transplant services. Option two-eligible individuals aren't eligible for any non-transplant related health care services from AHCCCS.

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

The effective date of enrollment for a new Title XIX member with MCC is the day AHCCCS takes the enrollment action. MCC is responsible for payment of medically necessary covered services retroactive to the member's beginning date of eligibility, as reflected in PMMIS.

The effective date of enrollment for a Title XXI member will be the first day of the month following notification to MCC. In the event that eligibility is determined on or after the 25th day of the month, eligibility will begin on the first day of the second month following the determination 42 CFR 457.1201(m), 42 CFR 457.1212.

In general, eligibility for AHCCCS medical assistance is determined on a month-by-month basis. A member may be eligible or ineligible for any specific month.

Rules that affect all programs:

- For a person that moves to Arizona from out of state, medical assistance eligibility can't start any earlier than the date of the move to Arizona.
- For a person that has been in jail, prison or another detention facility, medical assistance eligibility can't start any earlier than the date the person no longer meets the definition of an inmate.
- For a newborn child, medical assistance eligibility can't start any earlier than the newborn's date of birth.

Otherwise, the date eligibility starts varies by program. See the table below:

Program	Eligibility Begin Date
Medicare Savings Program (MSP)-QMB	QMB eligibility begins with the month following the month that QMB eligibility is determined.

Program	Eligibility Begin Date
Breast and Cervical Cancer Treatment Program (BCCTP)	BCCTP eligibility begins on the later of: • First day of the application month (the application month for BCCTP is the month of the BCCTP diagnosis); or • First day of the first month in which the member meets all the BCCTP eligibility requirements.
KidsCare	• If eligibility is determined by the 25th day of the month, eligibility begins with the first day of the following month. • If eligibility is determined after the 25th day of the month eligibility begins the first day of the second month following the determination.
All other programs	First day of a month, if the member is eligible at any time during that month.

Newborn Enrollment

Newborns born to AHCCCS eligible mothers enrolled at the time of the child's birth will be enrolled with the mother's MCC benefits (except as noted in the following paragraph), when newborn notification is received by AHCCCS. MCC is responsible for notifying AHCCCS of a child's birth to an enrolled member. Capitation for the newborn will be retroactive to the date of birth if notification is received no later than one day from the date of birth. In all other circumstances, capitation for the newborn will begin on the date notification is received by AHCCCS. The effective date of AHCCCS eligibility for the newborn will be the newborn's date of birth, and MCC is responsible for all covered services to the newborn, whether or not AHCCCS has received notification of the child's birth. AHCCCS is available to receive notification 24 hours a day, 7 days a week via the AHCCCS website. Each eligible mother of a newborn is sent a choice notice advising her of her right to choose a different MCC for her child; the date of the change will be the date of processing the request from the mother. If the mother doesn't request a change within 90 days, the child will remain with the mother's MCC benefits.

Eligibility Verification

Medicaid Programs

The state of Arizona through AHCCCS determines eligibility for the Medicaid programs. Payment for services rendered is based on eligibility and benefit entitlement. The contractual agreement between providers and MCC places the responsibility for eligibility verification on the provider of services.

Eligibility Listing for Medicaid Programs

Providers who contract with MCC may verify a member's eligibility and/or confirm PCP assignment by checking the following:

- MCC at (800) 424-5891

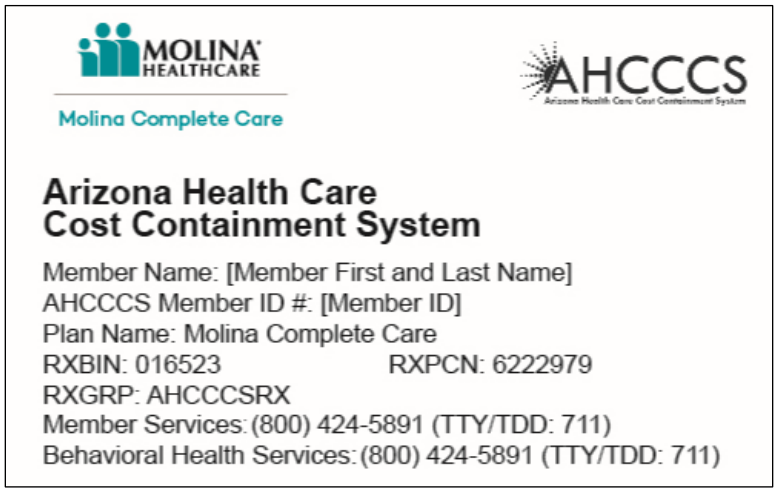
- Eligibility can also be verified through www.AZAHCCCS.gov
- Provider portal: www.availity.com/molinacompletecare

Possession of a Medicaid ID card doesn't mean a recipient is eligible for Medicaid services. A provider should verify a recipient's eligibility each time the recipient receives services. The verification sources can be used to verify a recipient's enrollment in a managed care plan. The name and telephone number of the managed care plan are given along with other eligibility information.

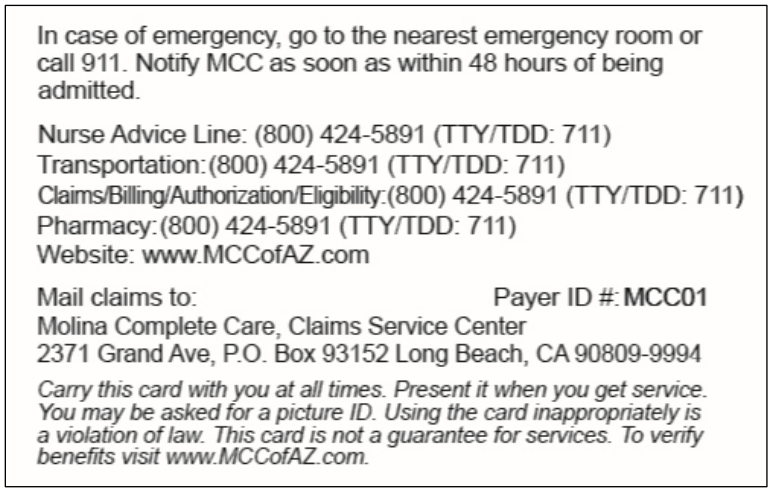
Identification Cards

MCC Sample Member ID Card

Card front



Card back



Members are reminded in their member handbook to carry ID cards with them when requesting medical or pharmacy services. It's the provider's responsibility to ensure MCC 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 can't produce the proper identification and eligibility cards.

Disenrollment

Voluntary Disenrollment

An AHCCCS member may request disenrollment at the following times:

1. For cause at any time, which includes: poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in addressing the member's care needs;
2. Without cause 90 days after initial enrollment or during the 90 days following notification of enrollment, whichever is later;
3. Without cause at least once every 12 months;
4. Without cause upon re-enrollment if a temporary loss of enrollment has caused the member to miss the annual disenrollment period.

When a member requests disenrollment for cause, the member must use MCC's grievance and appeal system process for the request, and MCC shall issue a decision no later than 30 days from the date of the request. If MCC approves the disenrollment, AHCCCS isn't required to make a determination.

The effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the member or MCC files the request.

Voluntary disenrollment doesn't preclude members from filing a grievance with MCC for incidents occurring during the time they were covered.

Involuntary Disenrollment

AHCCCS will disenroll the member from MCC:

1. When the member becomes ineligible for the AHCCCS program,
2. In certain situations when the member moves out of the Contractor's service area,
3. When the member changes Contractors during the member's open enrollment and annual enrollment choice period,
4. When the Contractor doesn't, because of moral or religious objections, cover the service the member seeks unless the Contractor offered a solution that was accepted by AHCCCS in accordance with the requirements in Section D, Paragraph 9, Scope of Services,
5. When the member is approved for a Contractor change through ACOM Policy 401,

6. When the member is eligible to transition to another AHCCCS program,
7. When the member needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk, or for cause.

PCP Assignment

PCP assignment for non-dual eligible members: MCC assigns all non-dual eligible members to a PCP at the date of the member's enrollment. Members may select a different in-network PCP at any time if they choose. When we call the member to schedule an initial assessment, we offer the member the opportunity to change their PCP assignment. Our experience shows that members often require highly specialized primary care services to address their complex needs, along with related services and supports. We prioritize PCP assignment with Federally Qualified Health Centers and integrated clinics, so members can receive primary care services at a location that best meets their needs.

PCP assignment for dual eligible members: For dual eligible members, we utilize all AHCCCS and Medicare information provided to us to identify the member's PCP and enhance our care management efforts. We assist the member in finding or changing a PCP, including contacting the individual's Medicare health plan care manager when necessary. We work with PCPs to coordinate care and invite the individual to participate in ICTs. We inform dual eligible members about their right to access Medicare providers, regardless of whether the provider is in our network, and without having to obtain prior approval.

7. BENEFITS AND COVERED SERVICES

This section provides an overview of the medical benefits and covered services for MCC members. Some benefits may have limitations. If there are questions as to whether a service is covered or requires prior authorization, please contact MCC at (800) 424-5891 Monday-Friday 8 a.m.-6 p.m. MST.

Member Cost Sharing

Cost sharing is the deductible, co-payment, or co-insurance that members must pay for covered services provided under their MCC plan. Additional details regarding cost sharing are listed in the summary of benefits.

It's the provider's responsibility to collect the co-payment and other member cost sharing from the member to receive full reimbursement for a service. The amount of the co-payment and other cost sharing will be deducted from the MCC payment for all claims involving cost sharing.

Covered Services

Service Covered by MCC

MCC covers the services described in the summary of benefits documentation. If there are questions as to whether a service is covered or requires prior authorization, please contact MCC at (800) 424-5891 Monday-Friday 8 a.m. to 6 p.m. MST.

Obtaining Access to Certain Covered Services

Non-Preferred Drug Exception Request Process

The provider may request a prior authorization for clinically appropriate drugs that're not covered under the member's Medicaid plan. Using the FDA label, community standards and high levels of published clinical evidence, clinical criteria is applied to requests for medications requiring prior authorization.

- For a standard exception request, the member and/or member's representative and the prescribing provider will be notified of MCC's decision within 24 hours of receiving the complete request.
- If the initial request is denied, a notice of denial will be sent in writing to the member and prescriber within 24 hours of receiving the complete request.
- Members will also have the right to appeal a denial decision, per any requirements set forth by AHCCCS.
- MCC will allow a 72-hour emergency supply of prescribed medication for dispensing at any time that a prior authorization isn't available. Pharmacists will use their professional judgment regarding whether or not there's an immediate need every

time the 72-hour option is utilized. This procedure won't be allowed for routine and continuous overrides.

Specialty Drug Services

Many self-administered and office-administered injectable products require prior authorization. In some cases, they'll be made available through a vendor that's designated by MCC. More information about our prior authorization process, including a link to the prior authorization request form, is available in the health care services section of this provider manual. Provider-administered drugs require the appropriate 11-digit NDC, with the exception of vaccinations or other drugs as specified by CMS.

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

Injectable and Infusion Services

Many self-administered and office-administered injectable products require prior authorization. In some cases, they'll be made available through a vendor that's designated by MCC. More information about our prior authorization process, including a link to the prior authorization request form, is available in the pharmacy section of this provider manual.

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

Access to Behavioral Health Services

Members in need of behavioral services can be referred by their PCP for services, or members can self-refer by calling Member Services at (800) 424-5891. MCC's 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 summary of benefits linked above, or by contacting MCC.

Emergency Mental Health or Substance Abuse Services

Members are directed to call 911 or go to the nearest emergency room if they need emergency services, mental health or substance abuse support. 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 medical or behavioral health emergency who can't get to a MCC-approved provider are directed to do the following:

- Go to the nearest emergency room.
- Call the number on their ID card.
- Call the member's PCP and follow-up within 24 to 48 hours.

For out-of-area emergency services, plans will need to transfer members to an in-network facility when the member is stable.

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 required. Emergency transportation includes, but is not limited to, ambulance, air or boat transports.

Non-Emergency Medical Transportation

MCC members receive non-emergent transportation services through the MCC non-emergency medical transportation network of providers. Contact MCC at (800) 424-5891 for additional information. Transportation assistance for trip recovery and after-hour discharges is available year-round, 24 hours a day, 7 days a week. Contact MCC at (800) 424-5891 and an on-call care coordinator or care manager will provide assistance.

Preventive Care

Preventive care guidelines are located online at www.MCCofAZ.com.

Preventive Health and Wellness

MCC has developed numerous education, promotion and outreach strategies. We continuously monitor the effectiveness of these strategies that encourage healthy behaviors. MCC ensures all members receive appropriate screenings, access to digital and mobile health apps and treatment, if needed. To promote self-care and personal responsibility, we offer member incentive programs that reward members for activities such as completing a preventive visit or health risk screening and assessment. By participating in these healthy behaviors, members can earn rewards that are loaded onto a Complete Care Counts reloadable debit card that can be used to purchase health-related services and supplies. To learn more, visit our website at www.MCCofAZ.com.

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) 424-5891.

Immunizations

Adult members may receive immunizations as recommended by the Centers for Disease Control and Prevention (CDC) and prescribed by the member's PCP. Child members may receive immunizations in accordance with the recommendations of the American Academy of Pediatrics (AAP) and prescribed by the child's PCP.

Immunization schedule recommendations from the AAP and/or the CDC are available online at: www.cdc.gov/vaccines/schedules/hcp/index.html.

MCC covers immunizations that aren't covered through Vaccines for Children (VFC).

Well Child Visits and EPSDT Guidelines

The federal Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit requires the provision of early and periodic screening services and well care examinations to individuals from birth until 21 years of age, with diagnosis and treatment of any health or mental health problems identified during these exams. The standards and periodicity schedule generally follow the recommendations from the AAP and Bright Futures. Learn more at www.AZAHCCCS.gov.

The screening services include:

- Comprehensive health and developmental history (including assessment of both physical and mental health development)
- Immunizations in accordance with the most current Arizona recommended childhood immunization schedule, as appropriate
- Comprehensive unclothed physical exam
- Laboratory tests as specified by the AAP, including screening for lead poisoning
- Health education
- Vision services
- Hearing services
- Dental services

When a screening examination indicates the need for further evaluation, providers must provide diagnostic services or refer members when appropriate without delay. Providers must provide treatment or other measures (or refer when appropriate) to correct or ameliorate defects and physical and mental illness or conditions discovered by the screening services.

We need your help conducting these regular exams in order to meet the AHCCCS-targeted state standard. Providers must use correct coding guidelines to ensure

accurate reporting for EPSDT services. If you have questions or suggestions related to EPSDT or well child care, please call our health education line at (800) 424-5891.

Prenatal Care

Stage of Pregnancy	How Often to See the Doctor
One month-six months	One visit a month
Seven months-Eight months	Two visits a month
Nine months	One visit a week

Emergency Services

Emergency services means: Those health care services that are rendered by participating or non-participating providers after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the member's health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; (2) serious impairment to bodily or mental functions; or (3) serious dysfunction of any bodily organ or part or behavior.

Emergent and urgent care services are covered by MCC without a prior authorization. This includes non-contracted providers inside or outside of MCC’s service area.

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, 7 days a week to assess symptoms and help make good health care decisions.

Phone: (800) 424-5891 (TTY/TDD: 711)

MCC 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

These registered nurses don’t 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 emergency room. By educating patients, it reduces costs and overutilization on the health care system.

Health Management Programs

Health Management

The tools and services described here are educational support for MCC members and may be changed at any time as necessary to meet the needs of MCC members.

Health Education and Disease Management

MCC offers programs to help our members and their families manage various health conditions. The programs include telephonic outreach from our clinical staff and health educators along with access to educational materials. You can refer members who may benefit from the additional education and support MCC offers. Members can request to be enrolled or disenrolled in these programs at any time. Our programs include:

- Asthma management
- Diabetes management
- High blood pressure management
- Heart failure
- Chronic obstructive pulmonary disease (COPD) management
- Depression management
- Obesity
- Weight management
- Smoking cessation
- Organ transplant
- Serious and persistent mental illness (SPMI) and substance use disorder
- Maternity screening and high-risk obstetrics

For more information about these programs, please call (800) 424-5891 (TTY/TDD: 711). (866) 472-9483 or TTY/TDD at 711 relay.

For additional information, please refer to the health care services section of this provider manual.

Telehealth and Telemedicine Services

MCC members may obtain covered services by participating providers through the use of telehealth and telemedicine services. Not all participating providers offer these services. The following additional provisions apply to the use of telehealth and telemedicine services:

- Services must be obtained from a participating provider
- Services are meant to be used when care is needed now for non-emergency medical issues
- Services are a method of accessing covered services and not a separate benefit

- Services aren’t permitted when the member and participating provider are in the same physical location
- Services don’t include texting, facsimile or email only
- Services include preventive and/or other routine or consultative visits during a pandemic
- Covered services provided through store-and-forward technology must include an in-person office visit to determine diagnosis or treatment

Upon at least 10 days prior notice to aprovider, MCC shall further have the right to a demonstration and testing of provider telehealth service platforms and operations. This demonstration may be conducted either virtually or face-to-face, as appropriate for telehealth capabilities and according to the preference of MCC. Providers shall make its personnel reasonably available to answer questions from MCC regarding telehealth operations.

For additional information on telehealth and telemedicine claims and billing, please refer to the claims and compensation section of this provider manual.

8. HEALTH CARE SERVICES

Introduction

Health care services is comprised of utilization management (UM) and care management (CM) departments that work together to achieve an integrated model based upon empirically validated best practices that have demonstrated positive results. Research and experience show that a higher touch, member-centric care environment for at-risk members supports better health outcomes. MCC provides CM services to members to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services. Elements of the MCC UM program include pre-service authorization review and inpatient authorization management that includes pre-admission, admission and concurrent review, medical necessity review and restrictions on the use of out-of-network providers.

Utilization Management

MCC ensures the service delivered is medically necessary and demonstrates an appropriate use of resources based on the level of care needed for a member. This program promotes the provision of quality, cost-effective and medically appropriate services that are offered across a continuum of care as well as integrating a range of services appropriate to meet individual needs. MCC maintains flexibility to adapt to changes in the member's condition, and is designed to influence member's care by:

- Managing available benefits effectively and efficiently while ensuring quality care
- Evaluating the medical necessity and efficiency of health care services across the continuum of care
- Defining the review criteria, information sources and processes that are used to review and approve the provision of items and services, including prescription drugs
- Coordinating, directing and monitoring the quality and cost effectiveness of health care resource utilization
- Implementing comprehensive processes to monitor and control the utilization of health care resources
- Ensuring services are available in a timely manner, in appropriate settings and are planned, individualized and measured for effectiveness
- Reviewing processes to ensure care is safe and accessible
- Ensuring qualified health care professionals perform all components of the UM processes
- Ensuring UM decision making tools are appropriately applied in determining medical necessity decisions

Key Functions of the UM Program

The table below outlines the key functions of the UM program. All prior authorizations are based on a specific standardized list of services.

Eligibility and Oversight	Resource Management	Quality Management
Eligibility verification	Prior authorization and referral management	Satisfaction evaluation of the UM program using member and provider input
Benefit administration and interpretation	Pre-admission, admission and inpatient review	Utilization data analysis
Verification that authorized care correlates to the member's medical necessity need(s) and benefit plan	Referrals for Discharge Planning and Care Transitions	Monitor for possible over utilization or underutilization of clinical resources
Verifying of current provider/hospital contract status	Staff education on consistent application of UM functions	Quality oversight
		Monitor for adherence to CMS, NCQA, state and health plan UM standards

For more information about MCC's UM program, or to obtain a copy of the HCS/Medical Management Program description, clinical criteria used for decision making, and how to contact a UM reviewer, access the MCC of AZ's website or contact the HCS department by calling (800) 424-5891

Medical groups/IPAs and delegated entities who assume responsibility for UM must adhere to MCC's UM policies. Their programs, policies and supporting documentation are reviewed by MCC at least annually.

UM Decisions

A decision is any determination made by MCC or the delegated medical group/IPA or other delegated entity with respect to the following:

- Determination to authorize, provide or pay for services (favorable determination);
- Determination to delay, modify, or deny payment of request (adverse determination);
- Discontinuation of a payment for a service;
- Payment for temporarily out-of-area renal dialysis services; and,
- Payment for emergency services, post stabilization care or urgently needed services.

MCC follows a hierarchy of medical necessity decision-making with federal and state regulations taking precedence. MCC covers all services and items required by state and federal regulations.

Board-certified licensed providers from appropriate specialty areas are utilized to assist in making determinations of medical necessity, as appropriate. All utilization decisions are made in a timely manner to accommodate the clinical urgency of the situation in accordance with federal and state regulatory requirements and NCQA standards.

Requests for authorization not meeting criteria are reviewed by a designated MCC medical director. Only a physician who holds a non-restricted license in Arizona and has appropriate clinical knowledge in the same or similar specialty that typically manages the condition, procedure or treatment under review will render decisions to make an adverse determination for an authorization based on medical necessity, authorize a request in an amount, duration, or scope that is less than requested, or make a decision involving excluded or limited services.

Providers can contact MCC's Health Care Services department at (800) 424-5891 to obtain MCC's UM criteria.

Medical Necessity

Medically necessary or medical necessity definition:

Medically Necessary-Per Arizona Medicaid, is a covered service provided by a physician or other licensed practitioner of the health arts within the scope of practice under State law to prevent disease, disability or other adverse conditions or their progression, or to prolong life as specified in A.A.C. R9-22-101

This is for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. Those services must be deemed by MCC to be:

1. In accordance with generally accepted standards of medical practice.
2. Clinically appropriate and clinically significant in terms of type, frequency, extent, site and duration. They're considered effective for the patient's illness, injury or disease.
3. Not primarily for the convenience of the patient, provider, or other health care provider. The services mustn't be 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. This literature is 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.

The fact that a provider has prescribed, recommended or approved medical or allied goods or services doesn't, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service and/or benefit.

MCG for Cite Guideline Transparency

MCC has partnered with MCG Health to implement Cite for Care Guideline Transparency. Providers can access this feature through the Provider Portal. With MCG for Cite Guideline Transparency, MCC can share clinical indications with Providers. The tool operates as a secure extension of MCC's existing MCG investment and helps meet regulations around transparency for delivery of care:

- Transparency—Delivers medical determination transparency.
- Access—Clinical evidence that payers use to support member care decisions.
- Security—Ensures easy and flexible access via secure web access.

MCG Cite for Care Guideline Transparency does not affect the process for notifying MCC of admissions or for seeking Prior Authorization approval. To learn more about MCG or Cite for Care Guideline Transparency, visit MCG's website or call (888) 464-4746.

Medical Necessity Review

MCC only reimburses for services that are medically necessary. Medical necessity review may take place prospectively as part of a pre-service request, concurrently as part of the inpatient admission notification/concurrent review, or retrospectively. To determine medical necessity, in conjunction with independent professional medical judgment, MCC uses nationally recognized evidence-based guidelines, third party guidelines, CMS guidelines, state guidelines, guidelines from recognized professional societies and advice from authoritative review articles and textbooks.

Levels of Administrative and Clinical Review

The MCC review process begins with administrative review followed by clinical review if appropriate. Administrative review includes verifying eligibility, appropriate vendor or participating provider, and benefit coverage. The Clinical review includes medical necessity and level of care.

All UM requests that may lead to an administrative or medical necessity adverse determination are reviewed by an MCC Medical Director.

MCC's Provider training includes information on the UM processes and Authorization requirements.

Clinical Information

MCC requires copies of clinical information be submitted for documentation and review. Clinical information includes but is not limited to:

- Physician emergency department notes
- Inpatient history/physical exams
- Pro-active discharge planning
- Discharge summaries
- Physician progress notes
- Physician office notes
- Physician orders
- Nursing notes
- Results of laboratory or imaging studies
- Therapy evaluations and therapist notes

Prior Authorization

MCC requires prior authorization for specified services, as long as the requirement complies with federal or state regulations and per the MCC Hospital or Provider Services Agreement. The list of services that require prior authorization is available on the Prior Auth LookUp Tool via the MCC of AZ Website. MCC prior authorization documents are customarily updated quarterly, but may be updated more frequently as appropriate, and are posted on the MCC website at www.MCCofAZ.com.

Providers are encouraged to use the MCC prior authorization form provided on the MCC website. If you're using a different form, the prior authorization request must include the following information:

- Member demographic information (name, date of birth, MCC (AHCCCS) ID number)
- Provider demographic information (referring Provider and referred to provider/facility, including address and NPI number).
- Member diagnosis and ICD-10 codes
- Requested service and/or procedure, including all appropriate CPT and HCPCS codes
- Physical location where service(s) will be performed
- Clinical information sufficient enough to document the medical necessity of the requested service is required, including but not limited to:
    - Pertinent medical history (include treatment, diagnostic tests and examination data)
    - Requested length of stay (applicable for inpatient requests)
    - Rationale for expedited processing. Expedited requests must meet the state definition or may be downgraded to standard requests per state requirements.

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. Obtaining authorization does not guarantee payment.

MCC retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care. MCC does not retroactively authorize services that require PA unless extenuating circumstances are present and provided with the authorization request. An extenuating circumstance is defined as: Provider did not know nor reasonably could have known the patient was an MCC member at the time service was rendered, or the Provider did not know nor reasonably could have known that the patient needed a service that required authorization prior to the service being rendered, or MCC error, or Special Provider contractual requirements. Retro- authorization with extenuating circumstances can evaluated by the UM Dept when the request is received within 10 business days of the provider becoming aware of the extenuating circumstance.

MCC makes UM decisions in a timely manner to accommodate the urgency of the situation, as determined by the member's clinical situation. The definition of expedited/urgent is any request for medical or behavioral health care or services with respect to which the application of time periods for non-urgent care determinations could seriously jeopardize the life, health, or safety of the member or others or the member's ability to regain maximum function, based on a prudent layperson's judgment, or in the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain or other adverse health consequences that cannot be adequately managed without the care or treatment that is the subject of the request. Supporting documentation is required to justify the expedited/urgent request.

For expedited/urgent requests for authorization, a determination is made as promptly as the member's health requires, and no later than 72 hours after we receive the initial request for service in the event a provider indicates, or if we determine that a standard authorization decision time frame could jeopardize a member's life or health. For a standard authorization request, MCC makes the determination and provides notification within 14 calendar days.

Providers who request prior authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. MCC has a full-time medical director available to discuss medical necessity decisions with the requesting provider. To speak to our medical director, please call (800) 424-5891.

Upon approval, the requestor will receive an authorization number. The number may be provided by telephone or fax. If a request is denied, the requestor and the member will receive a letter explaining the reason for the denial along with additional

information regarding the grievance and appeals process and peer to peer information as applicable. Denials also are communicated to the provider via fax.

Requesting Prior Authorization

Notwithstanding any provision in the provider agreement that requires providers to obtain a prior authorization directly from MCC, MCC may choose to contract with external vendors to help manage prior authorization requests.

For additional information regarding the prior authorization of specialized clinical services, please refer to the prior authorization tools located online at www.MCCofAZ.com:

- Prior authorization code look-up tool
- Prior authorization guide

Peer-to-Peer Review

Upon receipt of an adverse determination, the Provider (peer) may request a peer-to-peer discussion within five business days of the decision for prior authorization requests. For inpatient admissions, a request for a peer-to-peer discussion may be granted within five business days from the denial, prior to the member's discharge.

A "peer" is considered a physician, physician assistant, nurse practitioner, or PhD psychologist who is directly providing care to the member or a Medical Director on site at the facility.

Provider portal: Participating providers are encouraged to use the provider portal for prior authorization submissions whenever possible. Instructions for how to submit a prior authorization request are available on the provider portal. The benefits of submitting your prior authorization request through the provider portal include:

- Creating and submitting prior authorization requests
- Checking the status of prior authorization requests
- Receiving notification of changes in status of prior authorization requests
- Attaching medical documentation required for timely medical review and decision making

Fax: The prior authorization request form can be faxed to MCC at (888) 656-7501.

Inpatient requests/clinical can be faxed to MCC at (888) 656-2201.

Phone: Prior authorizations can be initiated by calling MCC at (800) 424-5891. It may be necessary to submit additional documentation before the authorization can be processed.

Emergency Services

Emergency services: Those health care services that are rendered by participating or non-participating providers after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the member's health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; (2) serious impairment to bodily or mental functions; or (3) serious dysfunction of any bodily organ or part or behavior.

Emergency medical condition or emergency: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, (1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn child.

A medical screening exam performed by licensed medical personnel in the emergency room and subsequent emergency services rendered to the member don’t require prior authorization from MCC.

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

MCC also provides Members a 24-hour Nurse Advice Line for medical advice. The 911 information is given to all Members at the onset of any call to the plan.

For members within our service area, MCC 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 facility.

Members overutilizing the emergency room will be contacted by MCC care managers to provide assistance whenever possible and determine the reason for using emergency services.

Care managers will also contact the PCP to ensure that members aren’t accessing the emergency room because of an inability to be seen by their PCP.

Inpatient Management

Elective Inpatient Admissions

MCC requires prior authorization for all elective and/or scheduled/planned inpatient admissions and procedures to any facility. Facilities are required to notify MCC within 24 hours, or by the following business day once the admission has occurred for concurrent review. Elective inpatient admission services performed without prior authorization may not be eligible for payment. MCC will review the medical necessity for continued stay, clinical is due within 24 hours or the following business day from when the next review date is set or from the last authorized day. In the event continued stay is denied, MCC will continue to work with the provider/facility to ensure safe discharge plan, coordination of care, and transition. Facilities are required to provide discharge plan with 24hrs or the following business day of MCC's request. Discharge date and disposition including discharge summary is due within 24 hours or the following business day of discharge.

Emergent Inpatient Admissions

MCC requires notification of all emergent inpatient admissions within 24 hours of admission, or by the following business day. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC) and initiate concurrent review and discharge planning. MCC requires that notification includes member demographic information, facility information, date of admission and clinical information sufficient to document the medical necessity of the admission. Emergent inpatient admission services performed without meeting admission notification, medical necessity requirements or failure to include all of the needed clinical documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient stay. MCC will review the medical necessity for continued stay, clinical is due within 24 hours or the following business day from when the next review date is set or from the last authorized day. In the event continued stay is denied, MCC will continue to work with the provider/facility to ensure safe discharge plan, coordination of care, and transition. Facilities are required to provide discharge plan with 24hrs or the following business day of MCC's request. Discharge date and disposition including discharge summary is due within 24 hours or the following business day of discharge.

Inpatient at time of Termination of Coverage

If a member's coverage with MCC terminates during a hospital stay, all services received after their termination of eligibility aren't covered services.

Inpatient/Concurrent Review

MCC performs concurrent inpatient review to ensure 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 facilities, including Behavioral Health Residential Facilities (BHRF). MCC will request updated clinical records from facilities at regular intervals during a member's stay. MCC requires that requested clinical information updates be received by MCC from the facility within 24 hours or the following business day of the request. In the event of a denial, MCC will continue to work with the provider/facility to ensure safe discharge plan, coordination of care, and transition. Facilities are required to provide discharge plan with 24hrs or the following business day of MCC's request. Discharge date and disposition including discharge summary is due within 24 hours or the following business day of discharge.

Failure to provide timely clinical information updates may result in denial of authorization for the remainder of the admission dependent on the provider contract terms and agreements.

MCC will authorize care when the clinical record supports the medical necessity for the need for continued stay. It's the expectation that observation has been tried in those patients that require a period of treatment or assessment, pending a decision regarding the need for additional care, and the observation level of care has failed. Upon discharge, the provider must provide MCC with a copy of member's discharge summary to include demographic information, date of discharge, discharge plan, instructions and disposition regardless of if stay was approved or denied and within 24hrs or next business day from the date of discharge.

Inpatient Status Determinations

MCC's UM staff follows the clinical hierarchy to determine if the collected 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 (refer to the medical necessity section of this Provider Manual).

Discharge Planning

The goal of discharge planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission. Discharge planning should begin on admission, continue throughout stay and facilitate a seamless transition post discharge. Facilities are required to provide discharge plan with 24hrs or the following business day of MCC's request. Discharge date and disposition including discharge summary is due within 24 hours or the following business day of discharge.

HCS staff work closely with the provider, facility, and/or discharge planners to determine the most appropriate discharge setting for our members. The clinical staff review medical necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), skilled nursing facility and rehabilitative services.

Readmissions

Readmission review is an important part of MCC's quality improvement program to ensure that MCC members are receiving care that's compliant with nationally recognized guidelines as well as federal and state regulations.

MCC will conduct readmission reviews when both admissions occur at the same acute inpatient facility within the state regulatory requirement dates.

When a subsequent admission to the same facility with the same or similar diagnosis occurs within 24 hours of discharge, the hospital will be informed that the readmission will be combined with the initial admission and will be processed as a continued stay.

When a subsequent admission to the same facility occurs within 72 hours of discharge and it's determined that the readmission is related to the first admission and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions.

A readmission is considered potentially preventable if it's clinically related to the prior admission and includes the following circumstances:

- Premature or inadequate discharge from the same hospital
- Issues with transition or coordination of care from the initial admission
- For an acute medical complication plausibly related to care that occurred during the initial admission

Readmissions that are excluded from consideration as preventable readmissions include:

- Planned readmissions associated with major or metastatic malignancies, multiple trauma and burns
- Neonatal and obstetrical readmissions
- Initial admissions with a discharge status of "left against medical advice" because the intended care wasn't completed
- Behavioral health readmissions
- Transplant-related readmissions

Post Service (Retrospective) Review

Failure to obtain authorization when required will result in denial of payment for those services, unless extenuating circumstances were present, and proof of extenuating circumstances are submitted with the request. An extenuating circumstance is defined as: Provider did not know nor reasonably could have known the patient was an MCC member at the time service was rendered, or the Provider did not know nor reasonably could have known that the patient needed a service that required authorization prior to the service being rendered, or MCC error, or Special Provider contractual requirements. Retro- authorization with extenuating circumstances can evaluated by the UM Dept when the request is received within 10 business days of the provider becoming aware of the extenuating circumstance. Decisions, in this circumstance, will be based on medical need, appropriateness of care guidelines defined by UM policies and criteria, regulation, guidance and evidence-based criteria sets.

Affirmative Statement about Incentives

All medical decisions are coordinated and rendered by qualified physicians and licensed staff unhindered by fiscal or administrative concerns. MCC and its delegated contractors don't use incentive arrangements to reward the restriction of medical care or behavioral health care to members.

MCC requires that all utilization-related decisions regarding member coverage and/or services are based solely on appropriateness of care and service and existence of coverage. MCC doesn't specifically reward practitioners or other individuals for issuing denials of coverage or care. MCC doesn't receive financial incentives or other types of compensation to encourage decisions that result in underutilization.

Out-of-Network Providers and Services

MCC maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process in order to provide medical care to MCC members. MCC requires members to receive medical care within the participating, contracted network of providers unless it's 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 receive prior authorization from MCC. Non-network providers may provide emergency services for a member who's temporarily outside the service area without prior authorization or as otherwise required by federal or state laws or regulations.

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.

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

Coordination of Care and Services

MCC HCS staff work with providers to assist with coordinating referrals, services and benefits for members who have been identified for MCC's Integrated Care Management (ICM) program via assessment or referral such as, self-referral, provider referral, etc. In addition, the coordination of care process assists MCC members, as necessary, in transitioning to other care when benefits end.

MCC staff provide an integrated approach to care needs by assisting members with identification of resources available to the member, such as community programs, national support groups, appropriate specialists and facilities, identifying best practice or new and innovative approaches to care. Care coordination by MCC staff is done in partnership with providers, members and/or their authorized representative(s) to ensure efforts are efficient and non-duplicative.

Continuity of Care and Transition of Members

It's MCC's policy to provide members with advanced notice when a provider they're 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. The out-of-network provider can provide continued services to members undergoing a course of treatment after they've terminated their contractual agreement if the following conditions exist at the time of termination:

- **Acute condition or serious chronic condition**- Following termination, the terminated provider will continue to provide covered services to the member up to 90 days or longer if necessary for a safe transfer to another provider as determined by MCC or its delegated medical group/IPA
- **High risk of second or third trimester pregnancy**- The terminated provider will continue to provide services following termination until postpartum services related to delivery are completed or longer if necessary for a safe transfer.

For additional information regarding continuity of care and transition of members, please contact MCC at (800) 424-5891.

Continuity and Coordination of Provider Communication

MCC 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.

Reporting of Suspected Abuse and/or Neglect

A vulnerable adult is a person who's receiving or may be in need of receiving community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of themself, or unable to protect themself against significant harm or exploitation. When working with children, one may encounter situations suggesting abuse, neglect and/or unsafe living environments.

Every person who knows or has reasonable suspicion that a child or adult is being abused or neglected must report the matter immediately. Specific professionals mentioned under the law as mandated reporters are:

- Physicians, dentists, interns, residents, or nurses
- Public or private school employees or child care givers
- Psychologists, social workers, family protection workers, or family protection specialists
- Attorneys, ministers, or law enforcement officers

Suspected abuse and/or neglect should be reported as follows:

Child Abuse

Arizona Department of Child Safety
(888) 767-2445 <(888) SOS-CHILD>

Adult Abuse

Arizona Adult Protective Services
(877) 767-2385 <(877) SOS-ADULT>

MCC's HCS teams will work with PCPs, medical groups/IPAs and other delegated entities who're obligated to communicate with each other when there's a concern that a member is being abused. Final actions are taken by the PCP, medical group/IPA other delegated entities or other clinical personnel. Under state and federal law, a person participating in good faith in making a report or testifying about alleged abuse, neglect, abandonment, financial exploitation or self-neglect of a vulnerable adult in a judicial or administrative proceeding may be immune from liability resulting from the report or testimony.

MCC will follow up with members that're reported to have been abused, exploited or neglected to ensure appropriate measures were taken and follow up on safety issues. MCC will track, analyze and report aggregate information regarding abuse reporting to the health care services committee and the proper state agency.

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 care manager provides the PCP with the member's ICP, ICT updates and information regarding the member's progress through the ICP when requested by the PCP. The PCP is responsible for the provision of preventive services and for the primary medical care of members.

Care Manager Responsibilities

The care manager collaborates with the member and any additional participants as directed by the member to develop an ICP that includes recommended interventions from member's ICT, as applicable. ICP interventions include the appropriate information to address medical and psychosocial needs and/or barriers to accessing care, care coordination to address member's health care goals, health education to support self-management goals and a statement of expected outcomes. Jointly, the care manager and the member/authorized representative(s) are responsible for implementing the plan of care. Additionally the care manager:

- Assesses the member to determine if the member's needs warrant care management
- Monitors and communicates the progress of the implemented ICP to the member's ICT as member needs warrant
- Serves as a coordinator and resource to the member, their representative and ICT participants throughout the implementation of the ICP and revises the plan as suggested and needed
- Coordinates appropriate education and encourages the member's role in self-management
- Monitors progress toward the member's achievement of ICP goals in order to determine an appropriate time for the member's graduation from the ICM program

Health Management

The tools and services described here are educational support for MCC members and may be changed at any time as necessary to meet the needs of MCC members. Level 1 Members can be engaged in the program for up to 60 days depending on Member preferences and the clinical judgement of the Health Management team.

Level 1 Health Management

MCC offers programs to help our members and their families manage various health conditions. The programs include telephonic outreach from our clinical staff and health educators that includes condition specific triage assessment, care plan development and access to tailored educational materials. Members are identified via Health Risk assessments and Identification and Stratification. You can also directly refer members who may benefit from these program offerings via MCC. Members can request to be enrolled or disenrolled in these programs at any time. Our programs include:

- Asthma management
- Diabetes management
- High blood pressure management
- Heart failure
- Chronic obstructive pulmonary disease (COPD) management
- Depression management
- Weight management
- Smoking/Tobacco cessation
- Substance use disorder
- Nutrition consult

For more information about these programs, please call (800) 424-5891 (TTY/TDD: 711).

Maternity Screening and High-Risk Obstetrics

MCC offers to all pregnant members prenatal health education with resource information as appropriate and screening services to identify high risk pregnancy conditions. Care managers with specialized OB training provide additional care coordination and health education for members with identified high risk pregnancies to assure best outcomes for members and their newborns during pregnancy, delivery and through their 6th week post-delivery. Pregnant member outreach, screening, education and care management are initiated by provider notification to MCC, member self-referral and internal MCC notification processes. Providers can notify MCC of pregnant/ high risk pregnant members via faxed Pregnancy Notification Report Forms.

Member Newsletters

Member newsletters are posted online at www.MCCofAZ.com at least once a year. The article topics are based on questions asked by members. The tips are aimed to help members stay healthy.

Member Health Education Materials

Members can access our easy-to-read evidenced-based educational materials about nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, diabetes, depression, and other relevant health topics identified during our engagement with Members. Materials are available through the Member Portal, direct mail as requested, email, and the My Molina mobile app.

Program Eligibility Criteria and Referral Source

Health management (HM) programs are designed for MCC members with a confirmed diagnosis. Identified members will receive targeted outreach, such as educational newsletters, telephonic outreach or other materials to access information on their condition. Members can contact Member Services at any time and request to be removed from the program.

Members may be identified for or referred to HM programs from multiple pathways which may include the following:

- Pharmacy claims data for all classifications of medications.
- Encounter data or paid claims with a relevant CMS accepted diagnosis or procedure code.
- Member Services welcome calls made by staff to new member households and incoming member calls with the potential to identify eligible program participants. Eligible members are referred to the program registry.
- Member assessment calls made by staff for the initial health risk assessments (HRA) for newly enrolled members.
- External referrals from provider(s), caregivers or community-based organizations.
- Internal referrals from the Nurse Advice Line, medication management or UM.
- Member self-referral due to general plan promotion of the program through the member newsletter or other member communications.

Provider Participation

Contracted providers are notified as appropriate, when their member is enrolled in an HM 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 HM programs, including how to enroll patients and outcomes of the programs
- Clinical practice guidelines
- Preventive health guidelines

Additional information on the HM programs is available from MCC toll free at (800) 424-5891.

Primary Care Providers

MCC provides a panel of PCPs to care for its Members. Providers in the specialties of Family Medicine, Internal Medicine and Obstetrics and Gynecology are eligible to serve as PCPs. Members may choose a PCP or have one selected for them by MCC. MCC's Members are required to see a PCP who is part of the MCC Network. MCC's Members may select or change their PCP by contacting MCC's Member & Provider Contact Center.

Specialty Providers

MCC maintains a network of specialty Providers to care for its Members. Some specialty care Providers may require a referral for a Member to receive specialty services; however, no prior authorization is required. Members are allowed to directly access women health specialists for routine and preventive health without a referral for services.

MCC will help to arrange specialty care outside the network when Providers are unavailable or the network is inadequate to meet a Member's medical needs. To obtain such assistance contact the MCC UM department. Referrals to specialty care outside the network require prior authorization from MCC.

Care Management

MCC provides a comprehensive ICM program to all members who meet the criteria for services. The ICM program focuses on coordinating the care, services and resources needed by members throughout the continuum of care. MCC adheres to the Case Management Society of America Standards of Practice Guidelines in its execution of the program.

MCC care managers may be licensed professionals and are educated, trained and experienced in MCC's ICM program. The ICM 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 ICM program is individualized to accommodate a member's needs with collaboration and input from the member's PCP. The MCC care manager will assess the member upon engagement after identification for ICM enrollment, assist with arrangement of individual services for members whose needs include ongoing medical care, home health care, rehabilitation services and preventive services. The MCC care manager is responsible for assessing the member's appropriateness for the ICM

program and for notifying the PCP of ICM program enrollment, as well as facilitating and assisting with the development of the member's ICP.

Referral to care management: Members with high-risk medical conditions and/or other care needs may be referred by their PCP or specialty care provider to the care management (CM) program. The care manager works collaboratively with the member and all participants of the ICT when warranted, including the PCP, and specialty providers such as discharge planners, ancillary providers, the local health department or other community-based resources when identified. The referral source should be prepared to provide the care 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 MCC ICM program for evaluation:

- High-risk pregnancy, including members with a history of a previous preterm delivery
- Catastrophic or end-stage medical conditions (e.g., neoplasm, organ/tissue transplants, end-stage renal disease)
- Comorbid chronic illnesses (e.g., asthma, diabetes, COPD, CHF, etc.)
- Preterm births
- High-technology home care requiring more than two weeks of treatment
- Member accessing emergency department services inappropriately
- Children with special health care needs

Referrals to the ICM program may be made by contacting MCC at:

Phone: (800) 424-5891
Fax: (888) 656-0369

9. BEHAVIORAL HEALTH

Overview

MCC provides a Behavioral Health benefit for Members. MCC takes an integrated, collaborative approach to behavioral health care, encouraging participation from PCPs, behavioral health, and other specialty Providers to ensure whole person care. All provisions within the Provider Manual are applicable to medical and behavioral health Providers unless otherwise noted in this section.

Utilization Management and Prior Authorization

Behavioral Health inpatient and residential services can be requested by submitting a Prior Authorization form or contacting MCC's Prior Authorization team at (800) 424-5891. Providers requesting after-hours authorization for these services should utilize Provider Portal or fax submission options. Emergency psychiatric services do not require Prior Authorization. All requests for Behavioral Health services should include the most current version of Diagnostic and Statistical Manual of Mental Disorders (DSM) classification. MCC utilizes standard, generally accepted Medical Necessity criteria for Prior Authorization reviews. Please see the Prior Authorization subsection found in the Health Care Services section of this Provider Manual for additional information.

Access to Behavioral Health Providers and PCPs

Members may be referred to an in-network Behavioral Health Provider via referral from a PCP or by Member self-referral. PCPs are able to screen and assess Members for the detection and treatment of, or referral for, any known or suspected Behavioral Health problems and disorders. PCPs may provide any clinically appropriate Behavioral Health service within the scope of their practice. A formal referral form or Prior Authorization is not needed for a Member to self-refer or be referred to a PCP or Behavioral Health Provider.

Members may be referred to PCP and specialty care Providers to manage their health care needs. Behavioral Health Providers may refer a Member to an in-network PCP, or a Member may self-refer. Behavioral Health Providers may identify other health concerns, including physical health concerns, that should be addressed by referring the Member to a PCP.

Care Coordination and Continuity of Care

Discharge Planning

Discharge planning begins upon admission to an inpatient or residential behavioral health facility. Members who were admitted to an inpatient or residential behavioral health setting must have an adequate outpatient follow-up appointment scheduled with a behavioral health Provider prior to discharge.

Interdisciplinary Care Coordination

In order to provide care for the whole person, MCC emphasizes the importance of collaboration amongst all Providers on the Member's treatment team. Behavioral Health, Primary Care, and other specialty Providers shall collaborate and coordinate care amongst each other for the benefit of the Member. Collaboration of the treatment team will increase communication of valuable clinical information, enhance the Member's experience with service delivery, and create opportunity for optimal health outcomes. MCC's Care Management program may assist in coordinating care and communication amongst all Providers of a Member's treatment team.

Care Management

MCC's Care Management team includes licensed nurses and clinicians with behavioral health experience to support Members with mental health and SUD needs. Members with high-risk psychiatric, medical or psychosocial needs may be referred by a Behavioral Health Provider to the CM program.

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

Phone: (800) 424-5891
Fax: (888) 656-0369

Additional information on the CM program can be found in the Care Management subsection found in the Health Care Services section of this Provider Manual.

Responsibilities of Behavioral Health Providers

MCC promotes collaboration with Providers and integration of both physical and behavioral health services in effort to provide quality care coordination to Members. Behavioral Health Providers are expected to provide in-scope, evidence-based mental health and substance use disorder services to MCC Members. Behavioral Health Providers may only provide physical health care services if they are licensed to do so.

Providers shall follow Quality standards related to access. MCC provides oversight of Providers to ensure Members are able to obtain needed health services within the acceptable appointment timeframes. Please see the Quality section of this Provider Manual for specific access to appointment details.

All Members receiving inpatient psychiatric services must be scheduled for a psychiatric outpatient appointment prior to discharge. The aftercare outpatient appointment must include the specific time, date, location, and name of the Provider. This appointment must occur within seven days of the discharge date. If a Member misses a behavioral health appointment, the Behavioral Health Provider shall contact the Member within 24 hours of a missed appointment to reschedule.

Behavioral Health Crisis Line

MCC has a Behavioral Health Crisis Line that may be accessed by Members 24/7 year-round. The Molina Behavioral Health Crisis Line is staffed by behavioral health clinicians to provide urgent crisis intervention, emergent referrals and/or triage to appropriate supports, resources, and emergency response teams. Members experiencing psychological distress may access the Behavioral Health Crisis Line by calling (800) 424-5891.

Behavioral Health Tool Kit for Providers

MCC has developed an online Behavioral Health Tool Kit to provide support with screening, assessment, and diagnosis of common behavioral health conditions, plus access to Behavioral Health HEDIS® Tip Sheets and other evidence-based guidance, and recommendations for coordinating care. The material within this tool kit is applicable to Providers in both primary care and behavioral health settings. The Behavioral Health Tool Kit for Providers can be found under the “Health Resources” tab on the MolinaHealthcare.com Provider website.

For those providers, specialists, members or family members seeking more information on the Court Ordered Evaluation or Court Ordered Treatment process, please utilize the below resources for additional information or they may contact MCC at (800) 424-5891 (TTY/TDD: 711) and request a care manager.

- www.azdisabilitylaw.org
- www.maricopa.gov/5220/Steps-in-the-mental-health-evaluation-pr
- https://www.azahcccs.gov/shared/Downloads/COE-COT_FAQ.pdf
- https://azcourtcare.org/

10. QUALITY

Maintaining Quality Improvement Processes and Programs

MCC works with members and providers to maintain a comprehensive quality improvement program. You can contact the MCC quality department by phone at (800) 424-5891 or by fax (888) 656-0369.

The address for mail requests is:

Molina Complete Care
Attn: Quality Department
5055 E Washington St, Suite 210
Phoenix, AZ 85034

This provider manual contains excerpts from the MCC quality improvement program. For a complete copy of MCC's quality improvement program, you can contact your provider services representative or call the telephone number above to receive a written copy.

MCC has established a quality improvement program that complies with regulatory requirements and accreditation standards. The quality improvement program provides structure and outlines specific activities designed to improve the care, service and health of our members. In our quality program description, we describe our program governance, scope, goals, measurable objectives, structure and responsibilities.

MCC doesn't delegate quality improvement activities to medical groups/IPAs. However, MCC requires contracted medical groups/IPAs to comply with the following core elements and standards of care. MCC medical groups/IPAs must:

- Have a quality improvement program in place
- Comply with and participate in MCC's quality improvement program, including reporting of access and availability survey, activity results and provision of medical records as part of the HEDIS® review process and during potential quality of care and/or critical incident investigations
- Cooperate with MCC's quality improvement activities that're designed to improve quality of care and services and member experience
- Allow MCC to collect, use and evaluate data related to provider performance for quality improvement activities, including, but not limited to, focus areas such as clinical care, care coordination and management, service access and availability
- Allow access to MCC quality personnel for site and medical record review processes

Access and Availability Standards

24-Hour Coverage

All providers must provide coverage 24hours a day, 7 days a week. Regular hours of operation must be clearly defined and communicated to the members, including arranging for on-call and after-hours coverage. Such coverage must consist of an answering service, call forwarding, provider call coverage or other customary means approved by MCC. The after-hours coverage must be accessible using the medical office's daytime telephone number, and the call must be returned within 30 minutes of initial contact.

Coverage During Absence

The provider must arrange for coverage of services during absences due to vacation, illness, or other situations that render the provider to be unable to provide services. An MCC participating provider must provide coverage.

Appointment Wait Time Requirement

The provider must offer appointments to our members in accordance with the state standards for timely access to care and services taking into account the urgency of the need for services and within the time frames outlined below.

Providers shall ensure that the provider's office staff is aware of and follows the standards as described in this provider manual. MCC monitors appointment availability standards of its providers on a routine basis to ensure that the provider's offices are compliant with these requirements as stipulated below and in accordance with AHCCCS ACOM Policy 417.

Additional information can be found online at:
www.tst.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/417_Appointment_Availability_Monitoring_and_Reporting.pdf

General appointment wait time standards:

- Emergency care services are available on the same day of the member request

PCP appointments:

- Urgent care appointments are available as expeditiously as the member's health condition requires, but no later than two business days of the request
- Routine sick care (non-urgent) appointments are available within one week of the request
- Routine care appointments are available within 21 calendar days of the request (*This standard doesn't apply to appointments for routine physical examinations or for regularly scheduled visits to monitor a chronic medical condition if the schedule calls*

for visits less frequently than once every 30 days, or for routine specialty services like dermatology, allergy care, etc.)

Specialty provider appointments:

- Urgent care appointments are available as expeditiously as the member's health condition requires, but no later than two business days of the request
- Routine care (non-urgent) appointments are available within 45 calendar days of the request

Dental provider appointments:

- Urgent care appointments are available as expeditiously as the member's health condition requires, but no later than three business days of the request
- Routine care (non-urgent) appointments are available within 45 calendar days of the request

Maternity care provider appointments:

- Initial prenatal care appointments for enrolled pregnant members shall be provided as follows:
  - First trimester- Within 14 calendar days of the request
  - Second trimester- Within seven calendar days of the request
  - Third trimester- Within three business days of the request
  - High-risk pregnancy- As expeditiously as the member's health condition requires, but no later than three business days of identification of high risk by MCC or by a maternity care provider, or immediately if an emergency occurs
- Emergency care services are available the same day of the member request

Behavioral health provider appointments:

- Urgent care appointments are available as expeditiously as the member's health condition requires, but no later than 24 hours of the request
- Routine care (non-urgent) appointments:
  - Initial assessment within seven calendar days of the referral or request for service
  - The first behavioral health service following the initial assessment: As expeditiously as the member's health condition requires, but no later than 23 calendar days after the initial assessment
  - All subsequent behavioral health services: As expeditiously as the member's health condition requires, but no later than 45 calendar days from identification of need

For psychotropic medications:

- Assess the urgency of the need immediately
- Provide an appointment, if clinically indicated, with a behavioral health medical

professional within a time frame that ensures the member:
(a) Doesn't run out of needed medications
(b) Doesn't decline in his/her behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need

Timely Medical Evaluation

The provider will ensure that all patients have a professional evaluation within one hour of their scheduled appointment time. If a delay is unavoidable, the patient will be informed and provided an alternative.

Member Panel

A PCP panel may hold up to 1,500 members. MCC monitors PCP panel size regular to ensure that panels don't go over the 1,500 limit. If a PCP wishes to close their panel prior to reaching 1,500, the PCP should reach out to their provider relations representative.

PCP and specialty care providers understand the importance of maintaining open accessibility of MCC members to appropriate and covered health care services, and agree to notify MCC immediately in the event that a PCP or specialty care provider is no longer able to accept new Medicaid members in the practice.

Patient Safety Program

MCC's patient safety program identifies appropriate safety projects and error avoidance for MCC members in collaboration with their PCPs. MCC continues to support safe personal health practices for our members through our safety program, pharmaceutical management and care management/disease management programs and education. MCC monitors nationally recognized quality index ratings for facilities, including adverse events and hospital acquired conditions as part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA) and Health and Human Services (HHS) to identify areas that have the potential for improving health care quality to reduce the incidence of events.

Quality of Care

MCC has established a systematic process to identify, investigate, review and report any potential quality of care, adverse event/never event, critical incident (as applicable) and/or service issues affecting member care. MCC will research, resolve, track and trend issues. Confirmed adverse events/never events are reportable when related to an error in medical care that's clearly identifiable, preventable and/or found to have caused serious injury or death to a patient. Some examples of never events include:

- Surgery on the wrong body part

- Surgery on the wrong patient
- The wrong surgery on a patient

MCC isn't required to pay for inpatient care related to "never events."

Medical Records

MCC requires that medical records are maintained in a manner that's 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. PCPs should maintain the following medical record components that include, but aren't limited to:

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

Medical Record Keeping Practices

Below is a list of the minimum items that're necessary in the maintenance of the member's medical records:

- Each patient has a separate record
- Medical records are stored away from patient areas and preferably locked
- Medical records are available at each visit, and archived records are available within 24 hours
- If in hard copy form, pages are securely attached in the medical record and records are organized by dividers or color-coded when the thickness of the records dictates
- If in electronic form, all those with access have individual passwords
- Record keeping is monitored for quality and HIPAA compliance
- Storage maintenance for the determined timeline and disposal per record management processes
- Process for archiving medical records and implementing improvement activities
- Medical records are kept confidential, and there's a process for release of medical records, including behavioral health care records

Content

Providers must remain consistent in their practices with MCC's medical record documentation guidelines. Medical records are maintained and should include the following information:

- Each page in the record contains the patient's name or ID number.

- Member name, date of birth, sex, marital status, address, employer, home and work telephone numbers and emergency contact
- Legible signatures and credentials of provider and other staff members within a paper chart.
- All providers who participate in the member's care.
- Information about services delivered by these providers.
- A problem list that describes the member's medical and behavioral health conditions.
- Presenting complaints, diagnoses and treatment plans, including follow-up visits and referrals to other providers.
- Prescribed medications, including dosages and dates of initial or refill prescriptions.
- Medication reconciliation within 30 days of an inpatient discharge should include evidence of current and discharge medication reconciliation and the date performed.
- Allergies and adverse reactions (or notation that none are known).
- Documentation that an advance directive, power of attorney and living will have been discussed with the member; a copy of an advance directive when in place.
- Past medical and surgical history, including physical examinations, treatments, preventive services and risk factors.
- Treatment plans that're consistent with diagnosis.
- A working diagnosis that is recorded with the clinical findings.
- Pertinent history for the presenting problem.
- Pertinent physical exam for the presenting problem.
- Lab and other diagnostic tests that're ordered as appropriate by the provider.
- Clear and thorough progress notes that state the intent for all ordered services and treatments.
- Notations regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed and included in the next preventive care visit when appropriate.
- Notes from consultants if applicable.
- Updated immunization records and documentation of appropriate history.
- All staff and provider notes are signed physically or electronically with either name or initials.
- All entries are dated.
- All abnormal lab/imaging results show explicit follow up plan(s).
- All ancillary services reports.
- Documentation of all emergency care provided in any setting.
- Documentation of all hospital admissions, inpatient and outpatient, including the hospital discharge summaries, hospital history, physicals and operative report.
- Labor and delivery record for any child seen since birth.
- A signed document stating with whom protected health information may be shared.

Organization

- The medical record is legible to someone other than the writer
- Each patient has an individual record
- Chart pages are bound, clipped, or attached to the file
- Chart sections are easily recognized for the retrieval of information
- A release document for each member authorizing MCC to release medical information for facilitation of medical care

Retrieval

- The medical record is available to the provider at each encounter
- The medical record is available to MCC for purposes of quality improvement
- The medical record is available to AHCCCS and the external quality review organization upon request
- The medical record is available to the member upon their request
- A storage system for inactive member medical records which allows retrieval within 24 hours, is consistent with state and federal requirements and the record is maintained for no less than 10 years from the last date of treatment or, for a minor, one year past their 20th birthday but never less than 10 years
- An established and functional data recovery procedure in the event of data loss

Confidentiality

MCC providers shall develop and implement confidentiality procedures to guard member protected health information in accordance with HIPAA privacy standards and all other applicable federal and state regulations. This should include, and is not limited to, the following:

- Ensure that medical information is released only in accordance with applicable federal or state law in pursuant to court orders or subpoenas
- Maintain records and information in an accurate and timely manner
- Ensure timely access by members to the records and information that pertain to them
- Abide by all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information
- Medical records are protected from unauthorized access
- Access to computerized confidential information is restricted
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information
- Education and training for all staff on handling and maintaining protected health care information

Additional information on medical records is available from your local MCC quality department. For additional information regarding HIPAA, please refer to the compliance section of this provider manual.

Access to Care

MCC maintains access to care standards and processes for ongoing monitoring of access to health care (including behavioral health care) provided by contracted PCPs (adult and pediatric) and participating specialists (to include OB/GYN, behavioral health providers and high volume and high impact specialists). 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 90 percent availability for emergency services and 90 percent or greater for all other services. The PCP or their designee must be available 24 hours a day, seven days a week to members.

Women's Health Access

MCC allows members the option to seek obstetric and gynecological care from an in-network obstetrician or gynecologist, or directly from a participating PCP designated by MCC 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. Gynecological services must be provided when requested, regardless of the gender status of the member.

Additional information on access to care is available from your local MCC quality department.

Monitoring Access for Compliance with Standards

Access to care standards are reviewed, revised as necessary and approved by the quality improvement committee on an annual basis.

Provider network adherence to access standards is monitored via one or more of the following mechanisms:

1. **Provider access studies**- Provider office assessment of appointment availability, after-hours access, provider ratios and geographic access
2. **Member complaint data**- Assessment of member complaints related to access and availability of care
3. **Member satisfaction survey**- Evaluation of member's self-reported satisfaction with appointment and after-hours access

Analysis of access data includes assessment of performance against established standards, review of trends over time and identification of barriers. Results of analysis

are reported to the quality improvement committee at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals aren't met and for identified provider-specific and/or organizational trends. Performance goals are reviewed and approved annually by the quality improvement committee.

Quality of Provider Office Sites

MCC providers are to maintain office site and medical record keeping practice standards. MCC continually monitors member appeals and complaints/grievances for all office sites to determine the need of an office site visit and will conduct office site visits as needed. MCC 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 includes an assessment of:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining room space

Physical Accessibility

MCC evaluates office sites as applicable to ensure that members have safe and appropriate access to the office site. This includes, but isn't limited to, ease of entry into the building, accessibility of space within the office site and ease of access for patients with physical disabilities.

Physical Appearance

The site visits include, but aren't limited to, an evaluation of office site cleanliness, appropriateness of lighting and patient safety as needed.

Adequacy of Waiting and Examining Room Space

During the site visit as required, MCC assesses waiting and examining room spaces to ensure that the office offers appropriate accommodations to members. The evaluation includes, but isn't limited to, appropriate seating in the waiting room areas and availability of exam tables in exam rooms.

Administration & Confidentiality of Facilities

Facilities contracted with MCC must demonstrate an overall compliance with the guidelines listed below:

- 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.

- Accessible parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway and the restroom is accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour and there's a minimum of two office exam rooms per provider.
- 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 of a hazardous waste management system in place.
- 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 aren't kept in exam rooms.
- Narcotics are locked, preferably double-locked. Medication and sample access is restricted.
- A system is in place to ensure expired sample medications aren't dispensed; injectables and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

Advance Directives (Patient Self-Determination Act)

MCC complies with the advance directive requirements of the states in which the organization provides services. Responsibilities include ensuring members receive information regarding advance directives and that contracted providers and facilities uphold executed documents.

Advance directives are a written choice for health care. There are two 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.

When there isn't an 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.

Providers must inform adult MCC members, 18 years and older, of their right to make health care decisions and execute advance directives. It's important that members are informed about advance directives.

New adult members or their identified personal representative will receive educational information and instructions on how to access advance directives forms in their member handbook, evidence of coverage (EOC) and other member communications such as newsletters and the MCC website. If a member is incapacitated at the time of enrollment, MCC will provide advance directive information to the member's family or representative and will follow up with information to the member at the appropriate time. All current members will receive annual notice explaining this information in addition to newsletter information.

Members who would like more information are instructed to contact Member Services or are directed to the CaringInfo website at caringinfo.org/planning/advance-directives/ for forms available to download. Additionally, the MCC website offers information to both providers and members regarding advance directives, with a link to forms that can be downloaded and printed.

PCPs must discuss advance directives with a member and provide appropriate medical advice if the member desires guidance or assistance.

MCC network providers and facilities are expected to communicate any objections they may have to a member directive prior to service when possible. Members may select a new PCP if the assigned provider has an objection to the member's desired decision. MCC will facilitate finding a new PCP or specialist as needed.

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 MCC or the state survey and certification agency if the member is dissatisfied with MCC's handling of advance directives and/or if a provider fails to comply with advance directive instructions.

MCC will notify the provider via fax of an individual member's advance directives identified through care management or care coordination. 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. Advance directives are state-specific to meet state regulations.

MCC will look for documented evidence of the discussion between the provider and the member during routine medical record reviews.

EPSDT Services to Enrollees Under 21 Years of Age

MCC maintains systematic and robust monitoring mechanisms to ensure all required EPSDT services to enrollees under 21 years of age are timely, according to required preventive guidelines. All enrollees under 21 years of age should receive preventive, diagnostic and treatment services at intervals as set forth in Section 1905 (R) of the Social Security Act. MCC's quality or the provider services department are also available to perform provider training to ensure that best practice guidelines are followed in relation to well child services and care for acute and chronic health care needs.

Well Child/Adolescent Visits

Visits consist of age-appropriate components that include but aren't limited to:

- Comprehensive health and developmental history
- Nutritional assessment
- Height and weight and growth charting
- Comprehensive unclothed physical examination
- Appropriate immunizations according to the advisory committee on immunization practices
- Laboratory procedures, including lead blood level assessment appropriate for age and risk factors
- Periodic developmental and behavioral screening using a recognized standardized developmental screening tool
- Vision and hearing tests
- Dental assessment and services
- Health education including anticipatory guidance such as child development, healthy lifestyles, accident and disease prevention)

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 aren't covered services.

MCC shall have no obligation to pay for services that aren't covered services.

Monitoring for Compliance with Standards

MCC monitors compliance with the established performance standards as outlined above at least annually. Performance below MCC's standards may result in a corrective action plan (CAP) with a request that the provider submit a written CAP to MCC 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 provider's permanent credentials file. If compliance isn't attained at follow-up, an updated CAP will be required. Providers who don't submit a CAP may be terminated from network participation, or closed to new members.

Quality Improvement Activities and Programs

MCC maintains an active quality improvement program. The quality improvement program 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.

Health Management and Care Management

The MCC health management and care management programs provide for the identification, assessment, stratification and implementation of appropriate interventions for members with chronic diseases.

For additional information, please see the Health Management and Care Management headings in the health care Services section of this provider manual.

Clinical Practice Guidelines

MCC adopts and disseminates clinical practice guidelines (CPG) 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. CPGs are reviewed at least annually, and more frequently as needed when clinical evidence changes, and approved by the quality improvement committee.

MCC CPGs include the following:

- Acute stress and post-traumatic stress disorder (PTSD)
- Anxiety/panic disorder
- Asthma
- Attention deficit hyperactivity disorder (ADHD)
- Bipolar disorder
- Children with special health care needs
- Chronic kidney disease
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Diabetes
- Heart failure in adults

- Hypertension
- Obesity
- Opioid management
- Perinatal care
- Pregnancy management
- Schizophrenia
- Sickle Cell Disease
- Substance abuse treatment
- Suicide risk
- Trauma-informed primary care

The adopted CPGs are distributed to the appropriate providers, provider groups, staff model facilities, delegates and members by the quality, provider services, health education and Member Services departments. The guidelines are disseminated through provider newsletters, electronic provider bulletins and other media and are available on the MCC website. Individual providers or members may request copies from your local MCC quality department.

Preventive Health Guidelines

MCC provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF), Bright Futures/American Academy of Pediatrics and Centers for Disease Control and Prevention (CDC), in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines. Diagnostic preventive procedures include but are not limited to:

- Adult Preventive Services Recommendations
- Recommendations for Preventive Pediatric Health Care
- Recommended Adult Immunization Schedule for ages 19 Years or Older, United States, 2021
- Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2021

All guidelines are updated at least annually and more frequently as needed when clinical evidence changes and are approved by the quality improvement committee. On an annual basis, preventive health guidelines are distributed to providers online at www.MCCofAZ.com and the provider manual. Notification of the availability of the preventive health guidelines are published in the MCC provider newsletter.

Cultural and Linguistic Services

MCC works to ensure all members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. For additional information about MCC's program and services, please see the cultural competency and linguistic services section of this provider manual.

Measurement of Clinical and Service Quality

MCC 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®)
- Behavioral health survey
- Provider satisfaction survey
- Effectiveness of quality improvement initiatives

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

Contracted providers and facilities must allow MCC 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. Reduced member cost sharing.

MCC's most recent results can be obtained from your local MCC quality department or by visiting our website at www.MCCofAZ.com.

Healthcare Effectiveness Data and Information Set

MCC utilizes the NCQA Healthcare Effectiveness Date and Information Set (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, diabetes care, well check-ups, medication use and cardiovascular disease.

HEDIS® results are used in a variety of ways. The results are the measurement standard for many of MCC's clinical quality 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 is also used to compare to established health plan performance benchmarks.

Consumer Assessment of Healthcare Providers and Systems

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is the tool used by MCC to summarize member satisfaction with the providers, health care and service they receive. CAHPS® examines specific measures, including getting needed care, getting care quickly, how well doctors communicate, coordination of care, customer service, rating of health care and getting needed prescription drugs. The CAHPS® survey is administered annually in the spring to randomly selected members by an NCQA-certified vendor.

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

Behavioral Health Satisfaction Assessment

MCC obtains feedback from members about their experience, needs and perceptions of accessing behavioral health care services. This feedback is collected at least annually to understand how our members rate their experiences in getting treatment, communicating with their clinicians, receiving treatment and information from the plan and perceived improvement in their conditions, among other areas.

Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey both focus on member experience with health care providers and health plans, MCC conducts a provider satisfaction survey annually. The results from this survey are very important to MCC as this is one of the primary methods used to identify improvement areas pertaining to the MCC provider network. The survey results have helped establish improvement activities related to MCC'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

MCC 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.

In addition to the methods described above, MCC also compiles complaint and appeals data as well as requests for out-of-network services to determine opportunities for service improvements

What Can Providers Do?

- Ensure patients are up-to-date with their annual physical exam and preventive health screenings, including related lab orders and referrals to specialists, such as ophthalmology
- Review the HEDIS® preventive care listing of measures for each patient to determine if anything applicable to your patients' age and/or condition has been missed
- Check that staff is properly coding all services provided
- Be sure patients understand what **they** need to do

MCC has additional resources to assist providers and their patients. For access to tools that can assist, please visit the provider portal. There're a variety of resources, including HEDIS® CPT/CMS-approved diagnostic and procedural code sheets. To obtain a current list of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey Star Ratings measures, contact your local MCC quality department.

11. COMPLIANCE

Fraud, Waste and Abuse

Introduction

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

MCC's Special Investigation Unit (SIU) supports compliance in its efforts to detect, deter and prevent fraud, waste and abuse by conducting investigations aimed at identifying suspect activity and reporting these findings to the appropriate regulatory and/or law enforcement agency.

Mission Statement

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

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 doesn't require proof of a specific intent to defraud the U.S. government. Instead, health care providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services,

submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted.

Deficit Reduction Act

The Deficit Reduction Act (DRA) aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

As a contractor doing business with MCC, providers and their staff have the same obligation to report any actual or suspected violation of Medicare/Medicaid funds either by fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and state laws pertaining to submitting false claims
- How providers will detect and prevent fraud, waste and abuse
- Employee protection rights as whistleblowers

These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims Act. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

Whistleblower protections state that employees who've been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to their role in disclosing or reporting a false claim are entitled to all relief necessary to make the employee whole including:

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

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

Anti-Kickback Statute- Provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable or reimbursable under the Medicare or other federal health care programs.

Stark Statute- Similar to the Anti-Kickback Statute, but more narrowly defined and applied. It applies specifically to services provided only by practitioners, rather than by all health care providers.

Sarbanes-Oxley Act of 2002- Requires certification of financial statements by both the chief executive officer and the chief financial officer. The act states that a corporation must assess the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

Definitions

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themself or some other person. It includes any act that constitutes fraud under applicable federal or state law. (42 CFR § 455.2)

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

Abuse: Provider practices that're inconsistent with sound fiscal, business, or medical practices and result in unnecessary costs to the state and federal health care programs, or in reimbursement for services that aren't medically necessary, or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the state and federal health care programs. (42 CFR § 455.2)

Examples of Fraud, Waste and Abuse by a Provider

The types of questionable provider schemes investigated by MCC include, but aren't limited to:

- A provider knowingly and willfully referring a member to health care facilities in which or with which the provider has a financial relationship. (Stark Law)
- Altering claims and/or medical record documentation in order to get a higher level of reimbursement.
- Balance billing a MCC member for covered services. This includes asking the member to pay the difference between the discounted and negotiated fees and the provider's usual and customary fees.
- Billing and providing for services to members that aren't medically necessary.
- Billing for services, procedures and/or supplies that haven't been rendered.
- Billing under an invalid place of service in order to receive or maximize reimbursement.
- Completing certificates of medical necessity for members not personally and professionally known by the provider.

- Concealing a member's misuse of a MCC identification card.
- Failing to report a member's forgery or alteration of a prescription or other medical document.
- False coding in order to receive or maximize reimbursement.
- Inappropriate billing of modifiers in order to receive or maximize reimbursement.
- Inappropriately billing of a procedure that doesn't match the diagnosis in order to receive or maximize reimbursement.
- Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients.
- Not following incident to billing guidelines in order to receive or maximize reimbursement.
- Overutilization.
- Participating in schemes that involve collusion between a provider and a member resulting in higher costs or charges.
- Questionable prescribing practices.
- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part, rather than using a single global code.
- Underutilization, which means failing to provide services that are medically necessary.
- Upcoding, which is when a provider doesn't bill the correct code for the service rendered and instead uses a code for a like services that costs more.
- Using the adjustment payment process to generate fraudulent payments.

Examples of Fraud, Waste and Abuse by a Member

The types of questionable member schemes investigated by MCC include, but aren't limited to the following:

- Benefit sharing with persons not entitled to the member's benefits.
- Conspiracy to defraud state and federal health care programs.
- 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 they don't suffer from, and the member sells the medication to someone else.

Review of Provider Claims and Claims System

MCC 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 that're billed in accordance with standardized billing practices; ensure that claims are processed accurately and ensure that payments reflect the service performed as authorized.

MCC 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're 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, MCC's claims payment system is designed to audit claims concurrently, in order to detect and prevent paying claims tha're inappropriate.

MCC has a prepayment claims auditing process that identifies frequent correct coding billing errors ensuring that claims are coded appropriately according to state and federal coding guidelines. Code edit relationships and edits are based on guidelines from specific state Medicaid guidelines, CMS, federal CMS guidelines, AMA and published specialty specific coding rules. Code edit rules are based on information received from the National Physician Fee Schedule Relative File (NPFS), the Medically Unlikely Edit (MUE) table, the National Correct Coding Initiative (NCCI) files, Local Coverage Determination/National Coverage Determination (LCD/NCD) and state-specific policy manuals and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).

Additionally, MCC may, at the request of a state program or at its own discretion, subject a provider to prepayment reviews whereupon provider is required to submit supporting source documents that justify an amount charged. Where no supporting documents are provided, or insufficient information is provided to substantiate a charge, the claim will be denied until such time that the provider can provide sufficient, accurate support.

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 MCC 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 MCC shall, in its sole

discretion, exercise the terms that're expressed in the provider agreement, the terms that are expressed here, its rights under law and equity, or some combination thereof.

Providers will provide MCC, governmental agencies and their representatives or agents, access to examine, audit and copy any and all records deemed by MCC, in MCC'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 MCC members. Auditable documents and records include, but aren't 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 MCC and without charge to MCC. In the event MCC identifies fraud, waste or abuse, provider agrees to repay funds, or MCC may seek recoupment.

If an MCC auditor is denied access to provider's records, all of the claims for which provider received payment from MCC 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. MCC may offset such amounts against any amounts owed by MCC to provider. Provider must comply with all requests for documentation and records timely (as reasonably requested by MCC) and without charge to MCC. Claims for which provider fails to furnish supporting documentation during the audit process aren't 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 MCC, provider is required to allow MCC 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.

Claim Auditing

MCC shall use established industry claims adjudication and/or clinical practices, state and federal guidelines and/or MCC's policies and data to determine the appropriateness of the billing, coding and payment.

Provider acknowledges MCC's right to conduct pre and post-payment billing audits. Provider shall cooperate with MCC's SIU and 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 as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, medical records upon MCC's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment.

In reviewing medical records for a procedure, MCC may select a statistically valid random sample, or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of claims that MCC paid in error. The estimated proportion, or error rate, may be projected across all claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal claims review, client-directed/regulatory investigation and/or compliance reviews and may be vendor assisted. MCC asks that you provide MCC, or MCC's designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If MCC's SSIU suspects that there is fraudulent or abusive activity, MCC may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, MCC reserves the right to recover the full amount paid or due to you.

Provider Education

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

MCC will notify the provider of the deficiency and will take steps to educate the provider, which may include the provider submitting a CAP to MCC addressing the issues identified and how it will cure these issues moving forward.

Reporting Fraud, Waste and Abuse

If you suspect cases of fraud, waste or abuse, you must report it by contacting the Molina AlertLine. The AlertLine is an external telephone and web-based reporting system hosted by NAVEX Global, a leading provider of compliance and ethics hotline services. The AlertLine telephone and web-based reporting is available 24 hours a day, seven 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 the AlertLine, a trained professional at NAVEX Global will note your concerns and provide them to the MCC 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 the AlertLine can be made from anywhere within the United States with telephone or internet access.

The Molina AlertLine can be reached toll free at (866) 606-3889, or you may use the service's website to make a report at any time at www.MolinaHealthcare.alertline.com.

You may also report cases of fraud, waste or abuse to MCC's compliance department. You have the right to have your concerns reported anonymously without fear of retaliation.

Molina Complete Care
Attn: Compliance
5055 E Washington St, Suite 210
Phoenix, AZ 85034

Remember to include the following information when reporting:

- The nature of the complaint
- The names of the individuals and/or entity involved in suspected fraud and/or abuse including address, phone number, MCC member ID number and any other identifying information

Suspected fraud and/or abuse may also be reported directly to the state.

To report suspected recipient fraud to AHCCCS, contact:

Provider Fraud

- In Maricopa County: (602) 417-4045
- Outside of Maricopa County: (888) ITS-NOT-OK or (888) 487-6686

Member Fraud

- In Maricopa County: (602) 417-4193
- Outside of Maricopa County: (888) ITS-NOT-OK or (888) 487-6686

If providers have questions about AHCCCS fraud, abuse of the program, or abuse of a member, please contact the AHCCCS Office of Inspector General (OIG).

Email: AHCCCSFraud@azahcccs.gov
Website: www.azahcccs.gov/Fraud/ReportFraud/

HIPAA Requirements and Information

HIPAA (The Health Insurance Portability and Accountability Act)

MCC's Commitment to Patient Privacy

Protecting the privacy of our members' personal health information is a core responsibility that MCC takes very seriously. MCC is committed to complying with all federal and state laws regarding the privacy and security of members' protected health information (PHI).

Provider Responsibilities

MCC expects that its contracted providers will respect the privacy of MCC members (including MCC members who aren't patients of the provider) and comply with all applicable laws and regulations regarding the privacy of patient and member PHI. MCC provides its members with a privacy notice upon their enrollment in our health plan. The

privacy notice explains how MCC uses and discloses their PHI and includes a summary of how MCC safeguards their PHI.

Telehealth/telemedicine providers: Telehealth transmissions are subject to HIPAA-related requirements outlined under state and federal law, including:

- 42 C.F.R. Part 2 Regulations
- Health Information Technology for Economic and Clinical Health Act, (HITECH Act)

Applicable Laws

Providers must understand all state and federal health care 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's a patchwork of laws that providers must comply with. In general, most health care providers are subject to various laws and regulations pertaining to privacy of health information, including, without limitation, the following:

1. **Federal Laws and Regulations**
   - HIPAA
   - The Health Information Technology for Economic and Clinical Health Act (HITECH)
   - 42 C.F.R. Part 2
   - Medicare and Medicaid Laws
   - The Affordable Care Act

2. **State Medical Privacy Laws and Regulations.**
   Providers should be aware that HIPAA provides a floor for patient privacy, but that state laws should be followed in certain situations, especially if the state law is more stringent than HIPAA. Providers should consult with their own legal counsel to address their specific situation.

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 health care operations activities (TPO) without the consent or authorization of the patient who's 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 health care provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a health care provider for the payment activities of the recipient. Please note that "payment" is

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

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 has had a relationship with the individual who's the subject of the PHI being requested, the PHI pertains to such relationship and the disclosure is for the following health care operations activities:
   - Quality improvement
   - Disease management
   - Care management and care coordination
   - Training programs
   - Accreditation, licensing and credentialing

   Importantly, this allows providers to share PHI with MCC for our health care operations activities, such as HEDIS® and quality improvement.

Confidentiality of Substance Use Disorder Patient Records

Federal Confidentiality of Substance Use Disorder Patients Records regulations apply to any entity or individual providing federally-assisted alcohol or drug abuse prevention treatment. Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with substance use disorder treatment or programs are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects substance use disorder information, the Federal Confidentiality of Substance Use Disorder Patients Records regulations are more restrictive than HIPAA and they don't allow disclosure without the member's written consent, except as set forth in 42 CFR Part 2.

Inadvertent Disclosures of PHI

MCC may, on occasion, inadvertently misdirect or disclose PHI pertaining to MCC member(s) who aren't the patients of the provider. In such cases, the provider shall return or securely destroy the PHI of the affected MCC members in order to protect their privacy. The provider agrees to not further use or disclose such PHI, and further agrees to provide an attestation of return, destruction and non-disclosure of any such misdirected PHI upon the reasonable request of MCC.

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

Written Authorizations

Uses and disclosures of PHI that aren't 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.

Patient Rights

Patients are afforded various rights under HIPAA. MCC providers must allow patients to exercise any of the rights listed below that apply to the provider's practice:

1. **Notice of Privacy Practices**
   Providers that're covered under HIPAA and 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 health care provider restrict its uses and disclosures of PHI. The provider isn't required to agree to any such request for restrictions.
3. **Requests for Confidential Communications**
   Patients may request that a health care 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-year period. The list of disclosures doesn't need to include disclosures made for treatment, payment, or health care operations or made prior to April 14, 2003.

HIPAA Security

Providers must implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability and integrity of MCC member and patient PHI. As more providers implement electronic health records, providers need to ensure that they

have implemented and maintain appropriate cybersecurity 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 health care industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity - such as health insurance information - without the person's knowledge or consent to obtain health care 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 MCC.

HIPAA Transactions and Code Sets

MCC strongly supports the use of electronic transactions to streamline health care administrative activities. MCC providers are encouraged to submit claims and other transactions to MCC 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

MCC is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers should refer to MCC's website at www.MCCofAZ.com for additional information regarding HIPAA standard transactions.

1. Click on the area titled "I'm a Health Care Professional"
2. Click the tab titled "HIPAA"
3. Click on the tab titled "HIPAA Transactions" or "HIPAA Code Sets"

Code Sets

HIPAA regulations require that only approved code sets may be used in standard electronic transactions.

National Provider Identifier

Providers 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 MCC and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within 30 days,

and should also be reported to MCC within 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 submitted to MCC.

Additional Requirements for Delegated Providers

Providers that're delegated for claims and UM activities are the "business associates" of MCC. Under HIPAA, MCC must obtain contractual assurances from all business associates that they'll safeguard member PHI. Delegated providers must agree to various contractual provisions required under HIPAA's Privacy and Security Rules.

Reimbursement for Copies of PHI

MCC doesn't reimburse providers for copies of PHI related to our members. These requests may include, although aren't limited to, the following purposes:

- UM
- Care coordination and/or complex medical care management services
- Claims review
- Resolution of an appeal and grievance
- Anti-fraud program review
- Quality of care issues
- Regulatory audits
- Risk adjustment
- Treatment, payment and/or operation purposes
- Collection of HEDIS® medical records

Business Continuity Plan (BCP)

The Provider will have a documented Business Continuity Plan (BCP) to ensure continuation and recovery of services after a disruption occurs. The BCP will be updated at least annually and approved by the applicable designated representative.

The Provider Business Continuity Plan will include:

- Names and contact information for staff responsible for invoking and managing response and recovery
- MCC notification names and contact information
- Disaster declaration process
- Details of how the services will be recovered and restored
- Details of how the systems and applications supporting the services will be recovered and restored, including recovery of data

The Provider will notify MCC of a disruption to the services or activation of business continuity plans within two hours and will provide MCC with regular updates on the

situation and actions taken to resolve the issue, until normal services have been resumed.

The Provider will ensure that its third-parties needed to deliver the services have appropriate Business Continuity Plans in place to prevent significant disruption to the services.

The Provider will test the BCP at least annually and document the test results. Provider will make available to MCC, upon request, the results of the most recent test including lessons learned and remediation plans.

The Provider will participate in MCC annual tests upon notification and mutual agreement.

After disruption to services, once normal service has been resumed, the Provider will promptly complete a root cause analysis report and provide it to MCC.

Definitions

Business Continuity Plan: documented procedures that guide organizations to respond, recover, resume and restore to a pre-defined level of operations following a disruption.

Disaster Recovery Plan: a document that defines the resources, actions, tasks and data required to manage the technology recovery effort.

Disaster Declaration: criteria to declare a disaster and the staff authorized to invoke recovery plans to recover and restore Services.

Cybersecurity Requirements

Note: This section is only applicable to providers who're delegated providers and have been delegated by MCC to perform a health plan function.

1. Provider shall comply with the following requirements and permit MCC to audit such compliance as required by law or any law enforcement agency.
2. The following terms are defined as follows:
    I. **Consumer** means an individual who's a state resident, whose non-public information is in MCC's possession, custody or control and which provider maintains, processes, stores or otherwise has access to such non-public information.
    II. **Cybersecurity event** means any act or attempt, successful or, to the extent known by provider, unsuccessful, to gain unauthorized access to, disrupt or misuse an information system or non-public information stored on such information system. The ongoing existence and occurrence of attempted but unsuccessful security incidents shall not constitute a cybersecurity event under this definition. **Unsuccessful security**

incidents are activities such as pings and other broadcast attacks on provider's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of MCC non-public information or sustained interruption of service obligations to MCC.

III. **Information System** or **Information systems** means a discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination or disposition of electronic non-public information, as well as any specialized system such as industrial or process controls systems, telephone switching and private branch exchange systems and environmental control systems.

IV. **Non-public information**" means information that isn't publicly available information and is one of the following:

(a) business-related information of MCC the tampering with which, or unauthorized disclosure, access, or use of which, would cause a material adverse impact to the business, operations, or security of MCC;

(b) any information concerning a consumer that because of the name, number, personal mark, or other identifier contained in the information can be used to identify such consumer, in combination with any one or more of the following data elements:

(i) social security number;

(ii) driver's license number, commercial driver's license or state identification card number;

(iii) account number, credit or debit card number;

(iv) security code, access code, or password that would permit access to a consumer's financial account; or

(v) biometric records;

(c) any information or data, except age or gender, in any form or medium created by or derived from a health care provider or a consumer, that can be used to identify a particular consumer and that relates to any of the following:

(i) the past, present, or future physical, mental or behavioral health or condition of a consumer or a member of the consumer's family;

(ii) the provision of health care to a consumer; or

(iii) payment for the provision of health care to a consumer.

V. "State" means the state of Arizona.

3. Provider shall implement appropriate administrative, technical and physical measures to protect and secure the information systems and non-public information, as defined herein, that're accessible to, or held by, the provider. Implementation of the foregoing measures shall incorporate guidance issued by the State Department of Insurance, as appropriate.

4. Provider agrees to comply with all applicable laws governing cybersecurity events. MCC will decide on notification to affected consumers or government entities. Upon MCC's prior written request, provider agrees to assume responsibility for informing all such consumers in accordance with applicable law.
5. In the event of a cybersecurity event, provider shall notify M's chief information security officer of such cybersecurity event by telephone and email (as provided below) as promptly as possible, but in no event later than 72 hours from a determination that a cybersecurity event has occurred. A follow-up notification shall be provided by mail at the address indicated below:

   Notification to Molina's chief information security officer shall be provided to:
   Molina Chief Information Security Officer
   Telephone: (844) 821-1942
   Email: CyberIncidentReporting@molinahealthcare.com

   Molina Chief Information Security Officer
   Molina Healthcare, Inc.
   200 Oceangate Blvd., Suite 100
   Long Beach, CA 90802

6. Upon provider's notification to MCC of a determination of a cybersecurity event, provider must promptly provide MCC any documentation required and requested by MCC to complete an investigation, or, upon written request by MCC, provider shall complete an investigation pursuant to the following requirements:
   (a) determine whether a cybersecurity event occurred;
   (b) assess the nature and scope of the cybersecurity event;
   (c) identify non-public information that may have been involved in the cybersecurity event; and
   (d) perform or oversee reasonable measures to restore the security of the information systems compromised in the cybersecurity event to prevent further unauthorized acquisition, release, or use of the non-public information.
7. Provider shall maintain records concerning all cybersecurity events for a period of at least five years from the date of the cybersecurity event or such longer period as required by applicable laws and produce those records upon request of MCC.
8. Provider must provide to MCC the documentation required and requested by MCC in electronic form. Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to MCC concerning the cybersecurity event. The information provided to MCC in the initial and subsequent notices must include as much of following information known to provider at the time of the notification:
   (a) the date of the cybersecurity event;

(b) a description of how the information was exposed, lost, stolen, or breached, including the specific roles and responsibilities of provider, if any;
(c) how the cybersecurity event was discovered;
(d) whether any lost, stolen, or breached information has been recovered and if so, how this was done;
(e) the identity of the source of the cybersecurity event;
(f) whether provider has filed a police report or has notified any regulatory, governmental or law enforcement agencies and if so, when such notification was provided;
(g) a description of the specific types of information acquired without authorization, which means particular data elements including, for example, types of medical information, types of financial information, or types of information allowing identification of the consumer;
(h) the period during which the information system was compromised by the cybersecurity event;
(i) the number of total consumers in the state affected by the cybersecurity event;
(j) the results of any internal review identifying a lapse in either automated controls or internal procedures, or confirming that all automated controls or internal procedures were followed;
(k) a description of efforts being undertaken to remediate the situation which permitted the cybersecurity event to occur;
(l) a copy of provider's privacy policy and if requested by MCC, the steps that provider will take to notify consumers affected by the cybersecurity event; and
(m) the name of a contact person who is both familiar with the cybersecurity event and authorized to act on behalf of provider.

In the event provisions of this section conflict with provisions of any other agreement between MCC and provider, the stricter of the conflicting provisions will control.

12. CLAIMS AND COMPENSATION

Electronic Claims Submission

MCC strongly encourages participating providers to submit claims electronically, including secondary claims. Electronic claims submission provides significant benefits to the provider, including:

- Helping to reduce operation costs associated with paper claims (printing, postage, etc.)
- Increasing accuracy of data and efficient information delivery
- Reducing claim delays since errors can be corrected and resubmitted electronically
- Eliminating mailing time which allows claims to reach MCC faster.

MCC offers the following electronic claims submission options:

- Submit claims directly to MCC via the provider portal
- Submit claims to MCC via your regular EDI clearinghouse using Payer ID MCC01

Provider Portal

The provider portal is a no-cost online platform that offers a number of claims processing features:

- Submit professional (CMS1500) and institutional (UB04) claims with attached files including medical records and information.
- Correct/void claims
- Add attachments, including medical records and information, to previously submitted claims
- Check claims status
- View electronic remittance advice (ERA) and explanation of payment (EOP).
- Create and manage claim templates
- Create and submit a claim appeal with attached files

Clearinghouse

MCC uses Change Healthcare as its gateway clearinghouse. Change Healthcare has relationships with hundreds of other clearinghouses. Typically, providers can continue to submit claims to their usual clearinghouse.

MCC accepts EDI transactions through our gateway clearinghouse for claims via the 837P for professional and 837I for institutional. It's 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 via a clearinghouse:

- You should receive a 999 acknowledgement from your clearinghouse
- You should also receive 277CA response file with initial status of the claims from your clearinghouse
- You should contact your local clearinghouse representative if you experience any problems with your transmission

Timely Claim Filing

Providers shall promptly submit to MCC claims for covered services rendered to members. All claims shall be submitted in a form acceptable to and approved by MCC and shall include all medical records pertaining to the claim if requested by MCC or otherwise required by MCC's policies and procedures. Claims must be submitted by the provider to MCC within 180 calendar days after the discharge for inpatient services or the date of service for outpatient services. If MCC isn't the primary payer under coordination of benefits or third-party liability, providers must submit claims to MCC on the payment date on the primary insurance EOP or MSN after final determination by the primary payer. Except as otherwise provided by law or provided by government program requirements, any claims that aren't submitted to MCC within these timelines shall not be eligible for payment, and provider hereby waives any right to payment.

Claim Submission

Participating providers are required to submit claims to MCC with appropriate documentation. Providers must follow the appropriate state and CMS provider billing guidelines. Providers must utilize electronic billing though a clearinghouse or the provider portal whenever possible, use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims) and use electronic Payer ID MCC01.

Providers must bill MCC 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.

NPI

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

Required Elements

The following information must be included on every claim:

- Member name, date of birth and MCC member ID number
- Member's gender
- Member's address

- Date(s) of service
- Valid international classification of diseases diagnosis and procedure codes
- Valid revenue, CPT or HCPCS for services or items provided
- Valid diagnosis pointers
- Total billed charges
- Place and type of service code
- Days or units as applicable
- Provider tax identification number (TIN)
- 10-digit NPI
- Rendering provider name as applicable
- Billing/pay-to provider name and billing address
- Place of service and type (for facilities)
- Disclosure of any other health benefit plans
- E-signature
- Service facility location information

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

EDI Claims Submission Issues

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

Paper Claim Submissions

Participating providers should submit claims electronically. If electronic claim submission isn't possible, please submit paper claims to the following address:

Molina Complete Care
Claims Service Center
2371 Grand Avenue
PO Box 93152
Long Beach, CA 90809-9994

Please keep the following in mind when submitting paper claims:

- Paper claims should be submitted on original red colored CMS 1500 claims forms
- Paper claims must be printed, using black ink

Corrected Claim Process

Providers may correct any necessary field of the CMS-1500 and UB-04 forms. The descriptions of each field for a CMS-1500.
Corrected Claims may be submitted electronically via EDI, the Provider Portal.

All Corrected Claims:

- Must be free of handwritten or stamped verbiage (paper Claims).
- Must be submitted on a standard red and white UB-04 or CMS-1500 Claim form (paper Claims).
- Original Claim number must be inserted in field 64 of the UB-04 or field 22 of the CMS-1500 of the paper Claim, or the applicable 837 transaction loop for submitting corrected claims electronically.
- The appropriate frequency code/resubmission code must also be billed in field 4 of the UB-04 and 22 of the CMS-1500.

Note: The frequency/resubmission codes can be found in the NUCC (National Uniform Claim Committee) manual for CMS-1500 Claim forms or the UB Editor (Uniform Billing Editor) for UB-04 Claim forms.

Corrected Claims must be sent within 30 days of the original remittance advice date.

EDI (Clearinghouse) Submission

837P

- In the 2300 Loop, the CLM segment (Claim information) CLM05-3 (Claim frequency type code) must indicate one of the following qualifier codes:
  - "1"-ORIGINAL (initial claim)
  - "7"–REPLACEMENT (replacement of prior claim)
  - "8"-VOID (void/cancel of prior claim)
- In the 2300 Loop, the REF *F8 segment (claim information) must include the original reference number (internal control number/document control number – ICN/DCN).

837I

- Bill type for UB claims are billed in loop 2300/CLM05-1. In Bill Type for UB, the "1" "7" or "8" goes in the third digit for "frequency".
- In the 2300 Loop, the REF *F8 segment (claim information) must include the original reference number (internal control number/document control number – ICN/DCN).

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

COB

Medicaid is the payer of last resort. Private and governmental carriers must be billed prior to billing MCC or medical groups/IPAs. Provider shall make reasonable inquiries of members to learn whether members have health insurance, benefits or covered services other than from MCC, or is entitled to payment by a third party under any other insurance or plan of any type, and provider shall immediately notify MCC of said entitlement. In the event that coordination of benefits occurs, provider shall be compensated based on the state regulatory COB methodology. Primary carrier payment information is required with the claim submission. Providers can submit claims with attachments, including EOB and other required documents by utilizing the provider portal. Providers can also submit this information through EDI and paper submissions.

TPL

MCC is the payer of last resort and will make every effort to determine the appropriate third-party payer for services rendered. MCC may deny claims when third party has been established and will process claims for covered services when probable TPL hasn't been established, or third-party benefits aren't available to pay a claim. MCC will attempt to recover any third-party resources available to members and shall maintain records pertaining to TPL collections on behalf of members for audit and review.

Hospital-Acquired Conditions and Present on Admission Program

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

The following is a list of CMS hospital acquired conditions. CMS reduces payment for hospitalizations complicated by these categories of conditions that weren't present on admission (POA):

1) Foreign object retained after surgery
2) Air embolism
3) Blood incompatibility
4) Stage III and IV pressure ulcers
5) Falls and trauma
    a) Fractures
    b) Dislocations
    c) Intracranial injuries
    d) Crushing injuries
    e) Burn
    f) Other injuries
6) Manifestations of poor glycemic control
    a) Hypoglycemic coma
    b) Diabetic ketoacidosis

c) Non-ketotic hyperosmolar coma
d) Secondary diabetes with ketoacidosis
e) Secondary diabetes with hyperosmolarity

7) Catheter-associated urinary tract infection (UTI)
8) Vascular catheter-associated infection
9) Surgical site infection following coronary artery bypass graft – mediastinitis
10) Surgical site infection following certain orthopedic procedures:
    a) Spine
    b) Neck
    c) Shoulder
    d) Elbow
11) Surgical site infection following bariatric surgery procedures for obesity
    a) Laparoscopic gastric restrictive surgery
    b) Laparoscopic gastric bypass
    c) Gastroenterostomy
12) Surgical site infection following placement of cardiac implantable electronic device (CIED)
13) Iatrogenic pneumothorax with venous catheterization
14) Deep vein thrombosis (DVT)/pulmonary embolism (PE) following certain orthopedic procedures
    a) Total knee replacement
    b) Hip replacement

What this Means to Providers

- Acute IPPS hospital claims will be returned with no payment if the POA indicator is coded incorrectly or missing
- No additional payment will be made on IPPS hospital claims for conditions that're acquired during the patient's hospitalization

If you'd like to find out more information regarding the Medicare HAC/POA program including billing requirements, the following CMS site provides further information: www.cms.hhs.gov/HospitalAcqCond/.

MCC Coding Policies and Payment Policies

Frequently requested information on MCC's Coding Policies and Payment Policies is available on the MolinaHealthcare.com website under the Policies tab. Questions can be directed to your Provider Services representative.

Reimbursement Guidance and Payment Guidelines

Providers are responsible for submission of accurate claims. MCC requires coding of both diagnoses and procedures for all claims. The required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM for diagnoses. For procedures, the Healthcare Common Procedure Coding System

Level 1 (CPT codes), Level 2 and 3 (HCPCS codes) are required for professional and outpatient claims. Inpatient hospital claims require ICD-10-PCS (International Classification of Diseases, 10th Revision, Procedure Coding System). Furthermore, MCC requires that all claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

MCC utilizes a claims adjudication system that encompasses edits and audits that follow state and federal requirements as well as administers payment rules based on generally accepted principles of correct coding. These payment rules include, but aren't limited to, the following:

- Manuals and Relative Value Unit (RVU) files published by CMS, including:
  - National Correct Coding Initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and Medically Unlikely Edits (MUE). In the event a state benefit limit is more stringent/restrictive than a federal MUE, MCC will apply the state benefit limit. Furthermore, if a professional organization has a more stringent/restrictive standard than a federal MUE or state benefit limit, the professional organization standard may be used.
  - In the absence of state guidance, Medicare National Coverage Determinations (NCD).
  - In the absence of state guidance, Medicare Local Coverage Determinations (LCD).
  - CMS Physician Fee Schedule RVU indicators.
- Current Procedural Technology (CPT) guidance published by the American Medical Association (AMA).
- ICD-10 guidance published by the National Center for Health Statistics.
- State-specific claims reimbursement guidance.
- Other coding guidelines published by industry-recognized resources.
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than state and federal guidelines.
- MCC policies based on the appropriateness of health care and medical necessity.
- Payment policies published by MCC.

Telehealth Claims and Billing

Providers must follow CMS guidelines as well as state-level requirements.

All telehealth claims for MCC members must be submitted to MCC with correct codes for the plan type. Use the telehealth place of service (POS) Code 02, which certifies that the service meets the telehealth requirements. By coding and billing a place of service 02 with a covered telehealth procedure code, the provider is certifying the member was present at an eligible originating site when the telehealth services were performed. Modifier GQ is required when applicable. GQ represents services provided not in real time such as remote patient monitoring or "store and forward" of information like

photographs. GT represents services provided in real time (such as through video consultations). Modifier 95 is used for commercial insurance in place of GT for a set of specific E&M codes as Medicare limits originating site to rural areas. Place of service 02 (telehealth) indicates that telehealth was the place of service. Qualifying telehealth units of service for an originating site must be billed with Q3014 for reimbursement of facility fee.

National Correct Coding Initiative (NCCI)

CMS has directed all federal agencies to implement NCCI as policy in support of Section 6507 of the Patient Affordable Care Act of March 23, 2010. Molina Healthcare, Inc. uses NCCI standard payment methodologies.

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

General Coding Requirements

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

CPT and HCPCS Codes

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

Modifiers

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

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

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

ICD-10-CM/PCS Codes

MCC utilizes International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and International Classification of Diseases 10th Revision, Procedure Coding System (ICD-10-PCS) billing rules and will deny claims that don't meet MCC's ICD-10 Claim Submission Guidelines. To ensure proper and timely reimbursement, codes must be effective on the dates of service (DOS) for which the procedure or service was rendered and not the date of submission. Refer to the ICD-10 CM/PCS Official Guidelines for Coding and Reporting on the proper assignment of principal and additional diagnosis codes.

POS Codes

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

Type of Bill

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

Revenue Codes

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

Diagnosis Related Group (DRG)

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

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

National Drug Code (NDC)

The 11-digit National Drug Code number (NDC) must be reported on all professional and outpatient claims when submitted on the CMS-1500 Claim form, UB-04 or its electronic equivalent.

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

Coding Sources

Definitions

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

- **Category I Code**- Procedures/services
- **Category II Code**- Performance measurement
- **Category III Code**- Emerging technology

HCPCS- HealthCare Common Procedural Coding System; a CMS maintained uniform coding system consisting of descriptive terms and codes that're used primarily to identify procedure, supply and durable medical equipment codes furnished by physicians and other health care professionals.

ICD-10-CM- International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM diagnosis codes are maintained by the National Center for Health Statistics,

Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).

ICD-10-PCS- International Classification of Diseases, 10th revision, Procedure Coding System used to report procedures for inpatient hospital services.

Claim Auditing

MCC shall use established industry claims adjudication and/or clinical practices, state and federal guidelines and/or MCC's policies and data to determine the appropriateness of the billing, coding and payment.

Provider acknowledges MCC's right to conduct pre and post-payment billing audits. Provider shall cooperate with MCC's SIU and 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 as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, medical records upon MCC's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment.

In reviewing medical records for a procedure, MCC may select a statistically valid random sample or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of claims MCC paid in error. The estimated proportion, or error rate, may be projected across all claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal claims review, client-directed/regulatory investigation and/or compliance reviews and may be vendor assisted. MCC asks that you provide MCC, or MCC's designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If MCC's SIU suspects that there's fraudulent or abusive activity, MCC may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, MCC reserves the right to recover the full amount paid or due to you.

Timely Claim Processing

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

The receipt date of a claim is the date MCC receives notice of the claim.

Electronic Claim Payment

Participating providers are required to enroll for EFT and 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 aren't required to be innetwork to enroll. MCC uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery. Additional information about EFT/ERA is available online at www.MCCofAZ.com or by contacting our provider services department.

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of Claim payment, MCC determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a Claim for such Overpayment. Providers will receive an overpayment request letter if the overpayment is identified in accordance with State and CMS guidelines. Providers will be given the option to either:

1. Submit a refund to satisfy overpayment,
2. Submit request to offset from future claim payments, or
3. dispute overpayment findings.

Instructions will be provided on the overpayment notice and overpayments will be adjusted and reflected in your remittance advice. The letter timeframes are MCCstandards and may vary depending on applicable state guidelines and contractual terms.

Overpayments related to TPL/COB will contain primary insurer information necessary for rebilling including the policy number, effective date, term date, and subscriber information. For members with Commercial COB, MCC will pursue reclamation billing for identified overpayments if the primary insurer is a Commercial payer, in which MCC will seek reimbursement of funds directly from the primary payer. Providers will not receive an overpayment request letter in these scenarios pursuant to state guidelines for commercial recoveries. For members with Medicare COB Molina will provide notice within 540 days from the claim's paid date if the primary insurer is a Medicare plan. A provider may resubmit the claim with an attached primary EOB after submission to the primary payer for payment. MCC will adjudicate the claim and pay or deny the claim in accordance with claim processing guidelines.

A Provider shall pay a Claim for an Overpayment made by MCC which the Provider does not contest or dispute within the specified number of days on the refund request letter mailed to the Provider. If a Provider does not repay or dispute the overpaid amount within the timeframe allowed MCC may offset the overpayment amount(s) against future payments made to the Provider.

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

Claim Reconsiderations/Resubmissions

Providers requesting review of claims incorrectly denied due to processing errors (reconsiderations), or resubmitting claims that're denied due to missing documentation, incorrect coding, etc. (resubmissions) should send these requests to our claims department for review. Reconsideration or resubmission requests must be received within one year from the date of service (discharge date), one year from eligibility update, or 60 days from MCC's last timely adverse action; whichever is later.

Additionally, the item(s) being resubmitted should be clearly marked as reconsideration or resubmission and must include the following documentation:

- Completed claims request for reconsideration form (CRRF) found on the provider portal and provider website. Please note that the form must be completed in its entirety in order to be processed.
- A corrected claim. The corrected claim should list the original or adjusted claim in the claim reference number.
- Any documentation to support the adjustment and a copy of the authorization form (if applicable) must accompany the reconsideration request.
- The claim number clearly marked on all supporting documents

Forms may be submitted via fax, secure email or mail. Reconsiderations/resubmissions requested via the CRRF may be sent to the following address:

Molina Complete Care
Claims Service Center
Attention: Reconsiderations/Re-submssions
2371 Grand Ave
P.O. Box 93152
Long Beach, CA 90809-9994

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

Balance Billing

The provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a member be liable to the provider for any sums that are the legal obligation of MCC to the provider. Balance billing a MCC

member for covered services is prohibited, other than for the member's applicable copayment, coinsurance and deductible amounts.

Fraud and Abuse

Failure to report instances of suspected fraud and abuse is a violation of the law and subject to the penalties provided by law. Please refer to the compliance section of this provider manual for more information.

Encounter Data

Each provider, capitated provider or organization delegated for claims processing is required to submit encounter data to MCC for all adjudicated claims. The data is used for many purposes, such as regulatory reporting, rate setting and risk adjustment, hospital rate setting, the quality improvement program and HEDIS® reporting.

Contractors may submit encounter files as often as desired throughout the month and within 210 days from the end date of service in order to meet state and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I – institutional, 837P – professional, and 837D – dental. Data must be submitted with claims level detail for all non-institutional services provided.

MCC has a comprehensive automated and integrated encounter data system capable of supporting all 837 file formats and proprietary formats if needed.

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

MCC has created 837P, 837I, and 837D companion guides with the specific submission requirements available to providers.

When encounters are filed electronically providers should receive two types of responses:

- First, MCC will provide a 999 acknowledgement of the transmission
  Second, MCC will provide a 277CA response file for each transaction

Provider Claims Dispute

Providers who disagree with the payment, denial or recoupment of a claim may send a claim dispute to us at:

Molina Complete Care
Attention: Provider Claims Disputes
5055 E Washington St, Suite 210

Phoenix, AZ 85034

Disputes may also be sent via e-mail to MCCAZ-PrvDisputes@molinahealthcare.com.

Claim disputes must be filed in writing no later than 12 months from the date of service (or date of discharge), 12 months after the date of eligibility posting, or within 60 days after the payment, denial or recoupment of a timely claim submission; whichever is later.

Unless the provider and MCC agree to a longer period, MCC must mail a notice of decision within 30 days from the date of dispute receipt (regardless of MCC entry).

13. MEMBER GRIEVANCES AND APPEALS

Definitions

MCC is required to have a system in place to respond to grievances and appeals received from members, and we're required to furnish information about the grievance and appeals processes to all network providers and subcontractors. MCC ensures that individuals making decisions regarding grievances or appeals:

- Aren't involved in any previous level of review or decision making or a subordinate of the decision maker
- Have the appropriate clinical expertise to make the decision

For questions regarding member grievances and appeals, please contact MCC at (800) 424-5891.

Member Grievance Process

AHCCCS defines a grievance as a member's expression of dissatisfaction with any matter, other than an adverse benefit determination. A grievance is any complaint or dispute expressing dissatisfaction with any aspect of the contractor's or provider's operations, activities, or behavior. A grievance may be filed at any time. With the member's written consent, a provider or authorized representative may file a grievance on behalf of a member. Possible subjects for grievances include, but aren't limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a PCP or employee of the contractor, or failure to respect the member's rights, as provided for in 42 CFR § 438.400 et seq.

MCC will maintain a system that meets, at a minimum, the following standards:

- Timely acknowledgement of receipt of each member grievance;
- Timely review of each member grievance – as expeditiously as the member's condition requires;
- Standard response, electronically, or in writing, to each member grievance within a reasonable time, but no later than 10 days after MCC receives the grievance, absent extraordinary circumstances. However, no grievances shall exceed 90 days for resolution. Contractor decisions on member grievances cannot be appealed. 42 CFR 438.408(a), 42 CFR 438.408(b)(1).

If a member or their authorized designee (provider, family member, etc.) needs help with filing a grievance, please call us at department tollfree at (800) 424-5891. Interpreter services are available. Our Member Services department is available from Monday-Friday 8 a.m. to 6 p.m. MST. Members may also submit a grievance via secure email to: MCCAZ-AppealGrieve@molinahealthcare.com or via mail to:

Molina Complete Care

Attn: Grievance and Appeals Department
5055 E Washington St, Suite 210
Phoenix, AZ 85034

Grievance Timelines

According to AHCCCS guidelines, absent extraordinary circumstances, MCC must resolve each grievance within 10 business days from the date of receipt of the grievance (regardless of point of plan entry).

Appeals

An appeal is the request for review of an adverse benefit determination 42 CFR 438.400(b). Adverse benefit determinations are any of the following:

- Denial or limited authorization of a requested service, including determinations based on the:
  - Type or level of service, requirements for medical necessity, appropriateness, setting or
  - Effectiveness of a covered benefit
- Reduction, suspension or termination of a previously authorized service
- Denial, in whole or in part, of payment for a service
- Failure to provide services in a timely manner, as defined by the state;
- Failure to act within the time frames provided in 42 CFR 438.408(b)(1) and (2) required for standard resolution of appeals and standard disposition of grievances; or
- Denial of a rural member's request to obtain services outside the Contractor's network under 42 CFR 438.52(b)(2)(ii), when the Contractor is the only Contractor in the rural area
- Denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, or other member financial liabilities.

Appeals Process

MCC supports the right of our members to request a review of adverse actions or benefit determinations ("adverse determination"). MCC accepts appeal requests from our members, their authorized representatives and their providers for any covered service that has been denied, reduced, suspended or terminated. A member's authorized representative may be anyone who is authorized to file the appeals request on behalf of the member, so long as the member has provided written permission. Examples of designees include a family member, legal guardian, provider or attorney.

Expedited Appeals Process and Timeline

MCC has an expedited review process for appeals if we or the member's provider determines that the time expended in a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. If a provider is filing an expedited appeal on behalf of an MCC member, a valid AOR/AUD/member's permission is required to file the appeal. We'll resolve all expedited appeals as expeditiously as the member's health condition requires, but no later than 72 hours from the date the Contractor receives the expedited appeal.

Members may file an expedited appeal with MCC within 60 calendar days from the date on the notice of adverse benefit determination. Appeals may be filed verbally, in writing, via fax or email.

Standard Appeals Process and Timeline

Members may file a standard appeal with MCC within 60 calendar days from the date on the notice of adverse benefit determination. Appeals may be filed verbally, in writing, via fax or email.

To file an appeal, members may call us at (800) 424-5891 (TTY/TDD: 711) Monday-Friday 8 a.m. to 6 p.m. MST. If needed, our agents will provide assistance in completing the appeal request. Interpreter services are available, as needed. Members may also send us their written appeal via:

Secure email: MCCAZ-AppealGrieve@molinahealthcare.com

Fax: (888) 656-7505

Mail:

Molina Complete Care
Attn: Grievance and Appeals Department
5055 E Washington St, Suite 210
Phoenix, AZ 85034

MCC will make a decision on an appeal within 30 calendar days from the initial date of receipt of the appeal. The written notification will include the decision and the reason for denial, including information on their second level appeal rights through the State Fair Hearing process with AHCCCS. This time may be extended by 14 calendar days if requested by the member or in the event MCC determines an extension is in the member's best interest.

Continuation of Benefits

While the appeal decision is being made, the member can continue to receive care for previously authorized services if the member requests a continuation of benefits either within 10 days of the date on the notice of adverse benefit determination, or by the date the change in services is scheduled to occur. If the final decision isn't in the member's favor, the member may be liable for the cost of the services if the services are upheld by MCC. If the final decision is in the member's favor, services will be reinstated within 72 hours for expedited and standard appeals.

State Fair Hearing Process

Members, their authorized representatives, or their provider have a right to appeal MCC's adverse determination on their appeal request through the State Fair Hearing process. Completion of MCC's appeal process is a prerequisite to filing for a State Fair Hearing. A member may also file for a State Fair Hearing if MCC fails to adhere to the required time frames for processing the member's appeal.

The appeal for a State Fair Hearing must be filed in writing within 120 days after receipt of MCC's appeal decision. Members needing assistance filing a State Fair Hearing may contact MCC at (800) 424-5891 (TTY/TDD: 711) Monday-Friday 8 a.m. to 6 p.m. MST. MCC will attend and defend our appeals decisions at all hearings or conferences in person or by phone as deemed necessary by AHCCCS.

If AHCCCS reverses a decision to deny, limit, or delay services, MCC must authorize the disputed services no later than 72 hours from the date MCC receives the notice reversing the decision. MCC doesn't have the right to appeal AHCCCS' appeal decisions.

Continuation of Benefits

While the State Fair Hearing decision is being made, the member can continue to receive care for previously authorized services if the member requests continuation of benefits either within 10 days of the date on the notice of adverse benefit determination, or by the date the change in services is scheduled to occur. If the final decision isn't in the member's favor, they may be liable for the services provided. If the final decision is in the member's favor, services will be reinstated within 72 hours.

Reporting

All grievance and appeal data, including provider-specific data, is reported quarterly to the member/provider satisfaction committee (MPSC) by the department managers for review and recommendation. A summary of the results is reported to the executive quality improvement committee (EQIC) quarterly. Annually, a quantitative/qualitative report will be compiled and presented to the MPSC and EQIC by the chairman of

MPSC; to be included in the organization's Grand Analysis of customer satisfaction and assess opportunities for improvement.

Appeals and grievances will be reported to the state on a monthly basis. Grievance and appeals reports will be reviewed monthly by the credentialing coordinator for inclusion in the trending of ongoing sanctions, complaints and quality issues.

Record Retention

MCC will maintain all grievance and related appeal documentation on file for a minimum of 10 years. In addition to the information documented electronically via call tracking in QNXT or maintained in other electronic files, MCC will retain copies of any written documentation submitted by the provider pertaining to the grievance and appeal process. Providers shall maintain records for a period not less than 10 years from the termination of the model contract, and retained further if the records are under review or audit until the review or audit is complete. (Providers shall request and obtain CC's prior approval for the disposition of records if the agreement is continuous.)

14. CREDENTIALING AND RECREDENTIALING

The purpose of the credentialing program is to assure the Molina Healthcare and its subsidiaries (MCC) network consists of quality providers who meet clearly defined criteria and standards. It is the objective of MCC to provide superior health care to the community. Additional information is available in the credentialing policy and procedure which can be requested by contacting your MCC provider services representative.

The decision to accept or deny a credentialing applicant is based upon primary source verification, secondary source verification and additional information as required. The information gathered is confidential, and disclosure is limited to parties who're 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 the standards of NCQA. The credentialing program is reviewed annually, revised and updated as needed.

Non-Discriminatory Credentialing and Recredentialing

MCC doesn't make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, gender identity, age, sexual orientation, ancestry, religion, marital status, health status, or patient types (e.g., Medicaid) in which the practitioner specializes. This doesn't preclude MCC from including in its network practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of members.

Types of Practitioners Credentialed & Recredentialed

Practitioners and groups of practitioners with whom MCC contracts must be credentialed prior to the contract being implemented. Practitioner types requiring credentialing include but are not limited to:

- Acupuncturists
- Addiction medicine specialists
- Audiologists
- Behavioral health care practitioners who are licensed, certified or registered by the state to practice independently
- Chiropractors
- Clinical social workers
- Dentists
- Doctoral or psychologists with a master's degree
- Licensed/certified midwives (non-nurse)
- Massage therapists
- Clinical social workers with a master's degree

- Clinical nurse specialists or psychiatric nurse practitioners with master's degrees
- Medical doctors (MD)
- Naturopathic physicians
- Nurse midwives
- Nurse practitioners
- Occupational therapists
- Optometrists
- Oral surgeons
- Osteopathic physicians (DO)
- Pharmacists
- Physical therapists
- Physician assistants
- Podiatrists
- Psychiatrists and other physicians
- Speech and language pathologists
- Telemedicine practitioners

Criteria for Participation in the MCC Network

MCC has established criteria and the sources used to verify these criteria for the evaluation and selection of practitioners for participation in the MCC network. These criteria have been designed to assess a practitioner's ability to deliver care. This policy defines the criteria that're applied to applicants for initial participation, recredentialing and ongoing participation in the MCC network. To remain eligible for participation, practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by MCC.

MCC reserves the right to exercise discretion in applying any criteria and to exclude practitioners who don't meet the criteria. MCC may, after considering the recommendations of the professional review committee, waive any of the requirements for network participation established pursuant to these policies for good cause if it's determined such waiver is necessary to meet the needs of MCC and the community it serves. The refusal of MCC to waive any requirement shall not entitle any practitioner to a hearing or any other rights of review.

Practitioners must meet the following criteria to be eligible to participate in the MCC network. The practitioner shall have the burden of producing adequate information to prove they meet all criteria for initial participation and continued participation in the MCC network. If the practitioner fails provide this information, the credentialing application will be deemed incomplete, and it'll result in an administrative denial or administrative termination from the MCC network. Practitioners who fail to provide this burden of proof don't have the right to submit an appeal.

- **Application**- Provider must submit to MCC a complete credentialing application either from CAQH ProView or other state-mandated practitioner application. The attestation must be signed within 120 days. Application must include all required attachments.
- **License, certification or registration**- Provider must hold a current and valid license, certification or registration to practice in their specialty in every state in which they'll provide care and/or render services for MCC members. Telemedicine practitioners are required to be licensed in the state where they're located, and the state the member is located.
- **DEA or CDS certificate** - Provider must hold a current, valid, unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Provider must have a DEA or CDS in every state where the provider provides care to MCC members. If a practitioner has never had any disciplinary action taken related to their DEA and/or CDS and has a pending DEA/CDS certificate or chooses not to have a DEA and/or CDS certificate, the practitioner must then provide a documented process that allows another practitioner with a valid DEA and/or CDS certificate to write all prescriptions requiring a DEA number. If a practitioner doesn't have a DEA or CDS because it has been revoked, restricted or relinquished due to disciplinary reasons, the practitioner isn't eligible to participate in the MCC network.
- **Specialty**- Provider must only be credentialed in the specialty in which they have adequate education and training. Provider must confine their practice to their credentialed area of practice when providing services to MCC members.
- **Education**- Providers must have graduated from an accredited school with a degree required to practice in their designated specialty.
- **Residency training**- Provider must have satisfactorily completed residency programs from accredited training programs in the specialties in which they're practicing. MCC only recognizes residency 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), the Royal College of Physicians and Surgeons of Canada. Oral surgeons must complete a training program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation (CODA). Training must be successfully completed prior to completing the verification. It isn't acceptable to verify completion prior to graduation from the program. As of July 2013, podiatric residencies are required to be three years in length. If the podiatrist hasn't completed a three-year residency, or isn't board certified, the podiatrist must have five years of work history practicing podiatry.
- **Fellowship training**- If the provider isn't board certified in the specialty in which they practice and hasn't completed a residency program in the specialty in which they practice, they must've completed a fellowship program from an accredited training program in the specialty in which they're practicing.
- **Board certification**- Board certification in the specialty in which the practitioner is practicing isn't required. Initial applicants who aren't board certified will be considered for participation if they have satisfactorily completed a residency program

from an accredited training program in the specialty in which they're practicing. MCC recognizes board certification only from the following boards:
  - American Board of Medical Specialties (ABMS)
  - American Osteopathic Association (AOA)
  - American Board of Foot and Ankle Surgery (ABFAS)
  - American Board of Podiatric Medicine (ABPM)
  - American Board of Oral and Maxillofacial Surgery
  - American Board of Addiction Medicine (ABAM)
  - College of Family Physicians of Canada (CFPC)
  - Royal College of Physicians and Surgeons of Canada (RCPSC)
  - Behavioral Analyst Certification Board (BACB)
  - National Commission on Certification of Physician Assistants (NCCPA)
- **General practitioners**- Practitioners who aren't board certified and haven't completed a training program from an accredited training program are only eligible to be considered for participation as a general practitioner in the MCC network. To be eligible, the practitioner must've maintained a primary care practice in good standing for a minimum of the most recent five years without any gaps in work history. MCC will consider allowing a practitioner who is/was board certified and/or residency trained in a specialty other than primary care to participate as a general practitioner if the practitioner is applying to participate as a PCP, urgent care or wound care practitioner. General practitioners providing only wound care services don't require five years of work history as a PCP.
- **Nurse practitioners and physician assistants**- In certain circumstances, MCC may credential a practitioner who isn't licensed to practice independently. In these instances, it would also be required that the practitioner providing the supervision and/or oversight be contracted and credentialed with MCC.
- **Work history**- Provider must supply most recent five-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds six months, the practitioner must clarify the gap verbally or in writing. The organization will document verbal clarification in the practitioner's credentialing file. If the gap in employment exceeds one year, the practitioner must clarify the gap in writing.
- **Malpractice history**- Provider must supply a history of malpractice and professional liability claims and settlement history in accordance with the application.
- **Professional liability insurance**- Provider must supply a history of malpractice and professional liability claims and settlement history in accordance with the application. Documentation of malpractice and professional liability claims, and settlement history is requested from the practitioner on the credentialing application. If there's an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.
- **State sanctions, restrictions on licensure or limitations on scope of practice**- Practitioner must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations and non-renewals. Practitioner must also disclose

any history of voluntarily or involuntarily 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's an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner. MCC will also verify all licenses, certifications and registrations in every state where the practitioner has practiced. At the time of initial application, the practitioner mustn't 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.

- **Medicare, Medicaid and other sanctions and exclusions**- Practitioner mustn't be currently sanctioned, excluded, expelled or suspended from any state or federally funded program including but not limited to the Medicare or Medicaid programs. Practitioner must disclose all Medicare and Medicaid sanctions. If there's an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner. Practitioner must disclose all debarments, suspensions, proposals for debarments, exclusions or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving federal contracts, certain subcontracts and certain federal assistance and benefits. If there's an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.
- **Medicare opt out**- Practitioners currently listed on the Medicare opt-out report may not participate in the MCC network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Social Security Administration death master file**- Practitioners must provide their social security number. That social security number shouldn't be listed on the Social Security Administration death master file.
- **Medicare preclusion list**- Practitioners currently listed on the preclusion list may not participate in the MCC network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Professional liability insurance**- Practitioner must have and maintain professional malpractice liability insurance with limits that meet MCC criteria. This coverage shall extend to MCC members and the practitioner's activities on MCC's behalf. Practitioners maintaining coverage under a federal tort or self-insured aren't required to include amounts of coverage on their application for professional or medical malpractice insurance.
- **Inability to perform**- Practitioner must disclose any inability to perform essential functions of a practitioner in their area of practice with or without reasonable

[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.

accommodation. If there's an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.

- **Lack of present illegal drug use**- Practitioner must disclose if they're currently using any illegal drugs/substances.
- **Criminal convictions**- Practitioners must disclose if they've ever had any criminal convictions. Practitioners mustn't have been convicted of a felony or pled guilty to a felony for a health care related crime including but not limited to health care fraud, patient abuse and the unlawful manufacturing, distribution or dispensing of a controlled substance.
- **Loss or limitations of clinical privileges**- At initial credentialing, practitioner must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the practitioner has had privileges. If there's an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner. At recredentialing, practitioner must disclose past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the practitioner has had privileges since the previous credentialing cycle.
- **Hospital privileges**- Practitioners must list all current hospital privileges on their credentialing application. If the practitioner has current privileges, they must be in good standing.
- **NPI**- Practitioner must have an NPI issued by CMS.

Notification of Discrepancies in Credentialing Information & Practitioner's Right to Correct Erroneous Information

MCC will notify the practitioner immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner. Examples include but aren't limited to actions on a license, malpractice claims history, board certification, sanctions or exclusions. MCC isn't required to reveal the source of information if the information isn't obtained to meet organization credentialing verification requirements or if disclosure is prohibited by law.

Practitioners have the right to correct erroneous information in their credentials file. Practitioner's rights are published on the MCC website and are included in this provider manual.

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

- Their requirement to submit a written response within 10 calendar days of receiving notification from MCC
- In their response, the practitioner must explain the discrepancy, may correct any erroneous information and may provide any proof that is available
- The practitioner's response must be sent to:

Molina Healthcare, Inc.
Attention: Credentialing Director
P.O. Box 2470
Spokane, WA 99210

Upon receipt of notification from the practitioner, MCC will document receipt of the information in the practitioner's credentials file. MCC will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the practitioner's credentials file. The practitioner will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with the practitioner's information, the credentialing department will notify the practitioner.

If the practitioner doesn't respond within 10 calendar days, their application processing will be discontinued, and network participation will be administratively denied or terminated.

Practitioner's Right to Review Information Submitted to Support Their Credentialing Application

Practitioners have the right to review their credentials file at any time. Practitioner's rights are published on the MCC website and are included in this provider manual.

The practitioner must notify the credentialing department and request an appointed time to review their file allowing up to seven calendar days to coordinate schedules. A medical director and the director responsible for credentialing, or the quality improvement director will be present. The practitioner has the right to review all information in the credentials file except peer references or recommendations protected by law from disclosure.

The only items in the file that may be copied by the practitioner are documents, which the practitioner sent to MCC (e.g., the application and any other attachments submitted with the application from the practitioner). Practitioners may not copy any other documents from the credentialing file.

Practitioner's Right to be Informed of Application Status

Practitioners have a right, upon request, to be informed of the status of their application by telephone, email or mail. Practitioner's rights are published on the MCC website and are included in this provider manual. MCC will respond to the request within two working days. MCC will share with the practitioner where the application is in the credentialing process and note any missing information or information not yet verified.

Notification of Credentialing Decisions

Initial credentialing decisions are communicated to practitioners via letter or email. This notification is typically sent by the MCC medical director within two weeks of the decision. Under no circumstance will notifications letters be sent to the practitioners later than 60 calendar days from the decision. Notification of recredentialing approvals aren't required.

Recredentialing

MCC recredentials every practitioner at least every 36 months.

Excluded Providers

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

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

Ongoing Monitoring of Sanctions and Exclusions

MCC monitors the following agencies for provider sanctions and exclusions between recredentialing cycles for all provider types and takes appropriate action against providers when occurrences of poor quality are identified. If an MCC provider is found to be sanctioned or excluded, the provider's contract will immediately be terminated effective the same date as the sanction or exclusion was implemented.

- **The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program**- Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs.
- **State Medicaid Exclusions**- Monitor for state Medicaid exclusions through each state's specific program integrity unit (or equivalent).

- **Medicare Exclusion Database (MED)**- MCC monitors for Medicare exclusions through CMS MED online application site.
- **Medicare Preclusion List**- Monitor for individuals and entities that are reported on the Medicare Preclusion List.
- **National Practitioner Database**- MCC enrolls all credentialed practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles.
- **System for Award Management (SAM)**- Monitor for Providers sanctioned with SAM.

MCC also monitors the following for all provider types between the recredentialing cycles:

- Member complaints/grievances
- Adverse events
- Medicare opt out
- Social Security Administration death master file

Provider Appeal Rights

In cases where the credentialing committee suspends or terminates a provider's contract based on quality of care or professional conduct, a certified letter is sent to the provider describing the adverse action taken and the reason for the action, including notification to the provider of the right to a fair hearing when required pursuant to laws or regulations.

15. DELEGATION

Delegation is a process that gives another entity the ability to perform specific functions on behalf of MCC. MCC may delegate:

1. Medical management
2. Credentialing and recredentialing
3. Sanction monitoring for employees and contracted staff at all levels
4. Claims
5. Complex care management
6. CMS Preclusion List monitoring
7. Other clinical and administrative functions

When MCC delegates any clinical or administrative functions, MCC remains responsible to external regulatory agencies and other entities for the performance of the delegated activities, including functions that may be sub-delegated. To become a delegate, the provider/accountable care organization (ACO)/vendor must be in compliance with MCC's established delegation criteria and standards. MCC's delegation oversight committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements. To remain a delegate, the provider/ACO/vendor must maintain compliance with MCC's standards and best practices.

Delegation Reporting Requirements

Delegated entities contracted with MCC must submit monthly and quarterly reports. Such reports will be determined by the function(s) delegated and reviewed by MCC delegation oversight staff for compliance with performance expectations within the timeline indicated by MCC.

Corrective Action Plans and Revocation of Delegated Activities

If it's determined that the delegate is out of compliance with MCC's guidelines or regulatory requirements, MCC may require the delegate to develop a corrective action plan designed to bring the delegate into compliance. MCC may also revoke delegated activities if it's determined that the delegate can't achieve compliance or if MCC determines that is the best course of action.

If you have additional questions related to delegated functions, please contact your MCC contract manager.

16. COVERED PHARMACY SERVICES

Prescription drug therapy is an integral component of your patient's comprehensive treatment program. MCC's goal is to provide our members with high quality, cost effective drug therapy. MCC works with our providers and pharmacists to ensure medications used to treat a variety of conditions and diseases are offered. MCC covers prescription and certain over-the-counter (OTC) drugs.

Pharmacy Policy

Prescription drug benefits are managed though MCC and are administered by a pharmacy benefit manager, CVS/Caremark. MCC offers coverage for outpatient prescription drugs listed on their preferred drug list (PDL). Medications not listed on the PDL will require prior authorization in order to be considered for approval.

MCC pharmacy claims are processed by CVS/Caremark. MCC members should obtain covered drugs from a pharmacy within the CVS/Caremark pharmacy network unless there's an emergency situation. The CVS/Caremark pharmacy network includes retail chain pharmacies, several local independent pharmacies and home infusion, mail order and specialty pharmacies. Additional information about the pharmacy network can be obtained by contacting MCC at (800) 424-5891.

Preferred Drugs

MCC uses a PDL. This is a list of prescription drugs approved by MCC for the use of our members and includes the approved AHCCCS PDL. Generic drugs, certain brand name drugs and certain specialty drugs listed in the PDL are covered. Some drugs, even though they're listed on the PDL, may have special limitations, such as quantity limits and age restrictions. Others may require the member to try and fail other preferred medications first. Non-PDL drugs may be requested through the service authorization process (see below). Some drugs are excluded from the pharmacy benefits, such as those for weight loss, infertility and cosmetic purposes. The PDL is available to providers on the MCC website at www.MCCofAZ.com.

The MCC formulary is one single tier. If a drug is on the list, it's considered Tier 1, which means it's a covered drug.

The PDL doesn't:

1. Require or prohibit the prescribing or dispensing of any medication;
2. Substitute for the independent professional judgment of the physician or pharmacist; or
3. Relieve the physician or pharmacist of any obligation to the patient or others.

Medication additions or deletions to the PDL reflect the decisions made by the Molina Complete Care pharmacy therapeutics (P&T) committee, and those decisions are inclusive of the AHCCCS PDL. The composition of the committee includes licensed pharmacists and medical doctors. Network providers have the right to submit formulary change requests to MCC by mail to:

Molina Complete Care
Attn to: MCC Pharmacy Director
5055 E Washington St, Suite 210
Phoenix, AZ 85034

The request must contain your clearly stated recommendation, reason for your recommendation and your contact information.

AHCCCS usually makes changes to the AHCCCS PDL quarterly. Those changes are also made to the MCC PDL quarterly. If a covered drug is removed from the PDL, MCC will send a written notification to the affected members at least 30 days before the change occurs. Providers are made aware of changes through provider bulletins that're emailed, faxed or posted to the provider portal.

Pharmacy Prior Authorizations

The PDL attempts to provide appropriate and cost-effective drug therapy to all participants covered by the MCC pharmacy program. If a patient requires medication that doesn't appear on the PDL, the physician can make a request for a non-preferred medication. It's anticipated that such exceptions will be rare and that PDL medications will be appropriate to treat the vast majority of medical conditions. In order for a member to receive coverage for a medication requiring prior authorization, the provider must initiate a service authorization request and indicate the reason for the exception. A service authorization request is the CVS/Caremark terminology for pharmacy prior authorization request. All relevant clinical information and previous drug history should be included. The request can be faxed or telephoned to:

Molina Complete Care
c/o CVS/Caremark

Fax: (844) 271-6887
Phone: (800) 424-5891
TTY/TDD: 711

You can find service authorization request forms online at www.MCCofAZ.com.

Denial of Pharmacy Services

If MCC denies a request for a service authorization, MCC will notify the provider via phone or fax within 24 hours of receipt of the request and issue a notice of action to the

prescriber and the member. The notice of action will include appeal rights and instructions for submitting an appeal.

OTC Items

Certain OTC items are covered for our members. The MCC PDL covers several OTC medications and can be obtained at a pharmacy with a prescription from a provider.

Emergency Supply Policy

All participating pharmacies are authorized to call the CVS/Caremark Pharmacy Helpdesk to request an override for a four-day supply of medication for an emergent situation. An emergent situation is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, b)serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part.

The following drug categories are not part of the MCC PDL and are excluded by AHCCCS; therefore, they **aren't covered by the emergency supply policy:**

1. Drugs used for anorexia or weight gain;
2. Drugs used to promote fertility;
3. Agents used for cosmetic purposes or hair growth;
4. Agents used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition other than sexual or erectile dysfunction, for which the agents have been approved by the FDA;
5. DESI (Drug Efficacy Study Implementation) drugs considered by the FDA to be less than effective. Compound prescriptions, which include a DESI drug, aren't covered;
6. Drugs that have been recalled;
7. Experimental drugs or non-FDA-approved drugs; and
8. Drugs marketed by a manufacturer who doesn't participate in the Medicaid Drug Rebate program.

Newly Approved Products

Newly approved drug products won' normally be placed on the PDL during their first six months on the market. During this period, access to these medications will be considered through the PA review process.

Pharmacy and Therapeutics Committee

The National Pharmacy and Therapeutics Committee (P&T) meets quarterly to review and recommend medications for formulary consideration. The P&T committee is organized to assist MCC with managing pharmacy resources and to improve the overall satisfaction of MCC members and providers. It seeks to ensure MCC members receive appropriate and necessary medications. An annual pharmacy work plan governs all the activities of the committee. The committee voting membership consists of external physicians and pharmacists from various clinical specialties.

Pharmacy Network

Members must use their MCC ID card to get prescriptions filled. Additional information regarding the pharmacy benefits, limitations and network pharmacies are available online at www.MCCofAZ.com or by calling MCC at (800) 424-5891.

Drug Formulary

The pharmacy program doesn't cover all medications. MCC keeps a list of drugs, devices, and supplies that are covered under the plan's pharmacy benefit. The list shows all the prescription and over-the-counter products Members can get from a pharmacy. Some medications require prior authorization (PA) or have limitations on age, dosage and/or quantities. Some medications require a PA or have limitations on age, dosage and/or quantities. For a complete list of covered medications, please visit www.MCCofAZ.com.

Information on procedures to obtain these medications is described within this provider manual and also available online at www.MCCofAZ.com.

Formulary Medications

In some cases, members may only be able to receive certain quantities of medication. Information on limits are included and can be found in the formulary document.

Formulary medications with PA requirements may require the use of first-line medications before they're approved.

Quantity Limitations

Quantity limitations have been placed on certain medications to ensure safe and appropriate use of the medication.

Age Limits

Some medications may have age limits. Age limits align with current U.S. FDA alerts for the appropriate use of pharmaceuticals.

Step Therapy

Plan restrictions for certain formulary drugs may require that other drugs be tried first. The formulary designates drugs that may process under the pharmacy benefit without prior authorization if the member's pharmacy fill history with MCC shows other drugs have been tried for certain lengths of time. If the member has trialed certain drugs prior to joining MCC, documentation in the clinical record can serve to satisfy requirements when submitted to MCC for review. Drug samples from providers or manufacturers aren't considered as meeting step therapy requirements or as justification for exception requests.

Non-Formulary Medications

Non-formulary medications may be considered for exception when formulary medications aren't appropriate for a particular member, or have proven ineffective. Requests for formulary exceptions should be submitted using a PA form. Clinical evidence must be provided and is taken into account when evaluating the request to determine medical necessity. The use of manufacturer's samples of non-formulary or "Prior Authorization Required" medications doesn't override formulary requirements.

Generic Substitution

Generic drugs should be dispensed when available. If the use of a particular brand name becomes medically necessary as determined by the provider, PA must be obtained through the standard PA process.

New to Market Drugs

Newly approved drug products won't normally be placed on the formulary during their first six months on the market. During this period, access to these medications will be considered through the PA process.

Medications Not Covered

Medications not covered by MCC are excluded from coverage. For example, drugs used in the treatment of fertility or those used for cosmetic purposes aren't part of the benefit.

Submitting a Prior Authorization Request

MCC will only process completed PA request forms. The following information **must** be included for the request form to be considered complete:

- Member first name, last name, date of birth and identification number
- Prescriber first name, last name, NPI, phone and fax number
- Drug name, strength, quantity and directions of use
- Diagnosis

MCC's decisions are based upon the information included with the PA request. Clinical notes are recommended. If clinical information and/or medical justification is missing, MCC will either fax or call your office to request clinical information be sent in to complete the review. To avoid delays in decisions, be sure to complete the form in its entirety, including medical justification and/or supporting clinical notes.

Fax a completed MCC prescription drug prior authorization drug form to MCC at (844) 271-6887. A blank, fillable and printable MCC prescription drug prior authorization drug form may be obtained online at www.MCCofAZ.com or by calling (800) 424-5891.

Member and Provider Patient Safety Notifications

MCC has a process to notify members and providers regarding a variety of safety issues which include voluntary recalls, FDA required recalls and drug withdrawals for patient safety reasons. This is also a requirement as an NCQA accredited organization.

Specialty Pharmaceuticals, Injectable and Infusion Services

Many specialty medications are covered by MCC through the pharmacy benefit using National Drug Codes (NDC) for billing and specialty pharmacy for dispensing to the member or provider. Some of these same medications may be covered through the medical benefit using Healthcare Common Procedure Coding System (HCPCS) via paper or electronic medical claim submission.

MCC, during the UM review process, will review the requested medication for the most cost-effective, yet clinically appropriate benefit (medical or pharmacy) of select specialty medications. All reviewers will first identify member eligibility, any federal or state regulatory requirements and the member-specific benefit plan coverage prior to determination of benefit processing.

If it's determined to be a pharmacy benefit, MCC's pharmacy vendor will coordinate with MCC 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 cost. Please contact your provider relations representative with any further questions about the program.

Newly FDA-approved medications are considered non-formulary and subject to non-formulary policies and other non-formulary utilization criteria until a coverage decision is rendered by the MCC pharmacy and therapeutics committee. “Buy-and-bill” drugs are pharmaceuticals which a provider purchases and administers, and for which the provider submits a claim to MCC for reimbursement.

Pain Safety Initiative (PSI) Resources

Safe and appropriate opioid prescribing and utilization is a priority for all of us in health care. MCC requires providers to adhere to MCC’s drug formularies and prescription policies designed to prevent abuse or misuse of high-risk chronic pain medication. Providers are expected to offer additional education and support to members regarding opioid and pain safety as needed.

MCC is dedicated to ensuring providers are equipped with additional resources, which can be found on the MCC website. Providers may access additional opioid safety and substance use disorder resources online at www.MCCofAZ.com under the Health Resource tab. Please consult with your provider services representative or reference the medication formulary for more information on MCC’s pain safety initiatives.

Prescription Monitoring and Pharmacy or Prescriber Lock In Program

MCC monitors controlled and non-controlled medications on an ongoing basis at least quarterly throughout the year. Monitoring includes the evaluation of prescription utilization by members, prescribing patterns by clinicians and dispensing by pharmacies. Drug utilization data is used to identify and screen high-risk members and providers who may facilitate drug diversion or present quality of care concerns.

MCC assigns members who meet certain evaluation parameters to an exclusive pharmacy and/or single prescriber for a minimum 12-month period. Criteria for pharmacy and/or prescriber member assignment include any of the following:

1. Overutilization:
    a. Member utilized the following in a three-month time period:
        - ≥ four prescribers; and
        - ≥ four different abuse potential drugs; and
        - ≥ four Pharmacies, **or**
    b. Member has received 12 or more prescriptions of the medications listed in section A-1 AHCCCS AMPM 310-FF in the past three months
2. Fraud- Member has presented a forged or altered prescription to the pharmacy
3. Referral from the MCC medical management clinical staff

In addition to exclusive pharmacy and/or prescriber restrictions, other interventions may include:

1. Member-specific point of sale safety edits and quantity limits as specified by the treating provider
2. Referral to a care manager for long-term follow-up care
3. Referral to a behavioral health service provider or other appropriate specialist

MCC members with one or more of the following conditions won't be subject to pharmacy and/or prescriber assignment or restriction:

1. Members with an active oncology diagnosis
2. Members receiving hospice care
3. Members residing in a skilled nursing facility

Members who are assigned to an exclusive pharmacy and/or an exclusive prescriber for 12 months are provided a written notice of action at least 30 days prior to the effective date of the assignment. Restrictions aren't implemented before providing members notice and opportunity for a hearing. If the member files a request for hearing, no restriction is imposed until such time that a resolution has been made.

Five Day Opioid Limit

MCC enforces the opioid days' supply limitation as required by AHCCCS.

Members under 18 years of age

A prescriber shall limit the initial and refill prescriptions for any short-acting opioid medication for a member under 18 years of age to no more than a five-day supply. An initial prescription for a short-acting opioid medication is one in which the member has not previously filled any prescription for a short-acting opioid medication within 60 days of the date of the pharmacy filling the current prescription as evidenced by the member's pharmacy benefit manager (PBM) prescription profile.

The initial and refill prescription five-day supply limitation for short-acting opioid medications doesn't apply to prescriptions for the following conditions and care instances:

- Active oncology diagnosis
- Hospice care
- End-of-life care (other than hospice)
- Palliative care
- Children on opioid wean at time of hospital discharge
- Skilled nursing facility care
- Traumatic injury, excluding post-surgical procedures
- Chronic conditions for which the provider has received PA approval through MCC

The initial prescription five-day supply limitation for short-acting opioid medications doesn't apply to prescriptions for post-surgical procedures. However, initial prescriptions for short-acting opioid medications for postsurgical procedures are limited to a supply of no more than 14 days. Refill prescriptions for short-acting opioid medications for post-surgical procedures are limited to no more than a five-day supply.

Members 18 years of age and older

A prescriber shall limit the initial prescription for any short-acting opioid medication for a member 18 years of age and older to no more than a five-day supply. An initial prescription for a short-acting opioid medication is one in which the member hasn't previously filled any prescription for a short-acting opioid medication within 60 days of the date of the pharmacy filling the current prescription as evidenced by the member's PBM prescription profile.

The initial prescription five-day supply limitation for short-acting opioid medications does not apply to prescriptions for the following conditions and care instances:

- Active oncology diagnosis
- Hospice care
- End-of-life care (other than hospice)
- Palliative care
- Skilled nursing facility care
- Traumatic injury, excluding post-surgical procedures
- Post-surgical procedures

Initial prescriptions for short-acting opioid medications for post-surgical procedures are limited to a supply of no more than 14 days.

Controlled Substances and E-Prescribing

From AHCCCS:

This information is to provide notification of the state of Arizona House Bill 2075 as it pertains to Electronic Prescribing of Controlled Substances and the links for additional information on available resources.

Beginning January 1, 2020, a Schedule II controlled substance that is an Opioid shall be dispensed only with an electronic prescription order as required by Federal Law or Regulation. The Arizona State Board of Pharmacy will not issue waivers to providers for this regulation.

This is a statutory mandate to all providers sending and pharmacies receiving Schedule II Opioid Prescriptions. Exceptions to HB2075 include federal facilities, for example, the Indian Health Service, the Department of Veterans Affairs and the Department of Defense; these facilities are not subject to this regulation.

For additional information regarding HB2075, please click the link below to the Arizona State Board of Pharmacy website to view the Frequently Asked Questions tab "E-Prescribing of Schedule II Opioids Mandate." www.pharmacy.az.gov/faq.

Please contact the AHCCCS pharmacy department at AHCCCSPharmacyDept@azahcccs.gov with any questions.

General and Informed Consent

Informed consent is required to be obtained from a member or legal guardian prior to the provision of the following services and procedures as outlined in AMPM 320-Q:

1. Complementary and Alternative Medicine (CAM),
2. Psychotropic medications,
3. Electro-Convulsive Therapy (ECT),
4. Use of telemedicine,
5. Application for a voluntary evaluation,
6. Research,
7. Admission for medical detoxification, an inpatient facility or a residential program (for members determined to have a Serious Mental Illness), and
8. Procedures or services with known substantial risks or side effects

Any member who is 18 years or older will need to give voluntary general consent to treatment for any of the above-mentioned procedures. The provider will need to demonstrate consent within the medical record via a signed general consent form. For members under the age of 18, the parent, legal guardian or a lawfully authorized custodial agency (including foster care givers A.R.S. 8.514.05 (C) and (D) will give general consent for treatment. The provider will need to demonstrate this consent within the medical record via a signed general consent form by the legal representative.

Prior to signing the general consent form the member and/or legal representative must be fully informed of the consequences, benefits and risks of treatment and understands their rights not to consent to receive specific behavioral health services. Member's over 18 years of age and/or the legal representative may refuse medications unless the member is required by a court order to take prescribed medications or in an emergency situation. Providers who are treating members in an emergency situation are not required to obtain general consent prior to treatment.

The comprehensive clinical record must include documentation of the essential elements for obtaining informed consent. Essential elements for obtaining informed consent for psychotropic medication are contained in a sample form that can be accessed online at www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/310V1.pdf. The use of the sample form is recommended as a tool to document informed consent for psychotropic medications.

17. RISK ADJUSTMENT MANAGEMENT PROGRAM

What is Risk Adjustment?

CMS defines risk adjustment as a process that helps accurately measure the health status of a plan's membership based on medical conditions and demographic information.

This process helps ensure health plans receive accurate payment for services provided to MCC members and prepares for resources that may be needed in the future to treat members who have multiple clinical conditions.

Why is Risk Adjustment Important?

MCC relies on our provider network to take care of our members based on their health care needs. Risk adjustment looks at a number of clinical data elements of a member's health profile to determine any documentation gaps from past visits and identifies opportunities for gap closure for future visits. In addition, risk adjustment allows us to:

- Focus on quality and efficiency
- Recognize and address current and potential health conditions early
- Identify members for care management referral
- Ensure adequate resources for the acuity levels of MCC members
- Have the resources to deliver the highest quality of care to MCC members

Your Role as a Provider

As a provider, your complete and accurate documentation in a member's medical record and submitted claims are critical to a member's quality of care. We encourage providers to code all diagnoses to the highest specificity as this will ensure MCC receives adequate resources to provide quality programs to you and our members.

For a complete and accurate medical record, all provider documentation must:

- Address clinical data elements (e.g. diabetic patient needs an eye exam or multiple comorbid conditions) provided by MCC and reviewed with the member
- Be compliant with CMS correct coding initiative
- Use the correct ICD-10 code by coding the condition to the highest level of specificity
- Only use diagnoses codes confirmed during a provider visit with a member. The visit may be face-to-face, or telehealth, depending on state or CMS requirements.
- Contain a treatment plan and progress notes
- Contain the member's name and date of service
- Have the provider's signature and credentials

RADV Audits

As part of the regulatory process, state and/or federal agencies may conduct risk adjustment data validation (RADV) audits to ensure that the diagnosis data submitted by MCC is appropriate and accurate. All claims/encounters submitted to MCC are subject to state and/or federal and internal health plan auditing. If MCC is selected for a RADV audit, providers will be required to submit medical records in a timely manner to validate the previously submitted data.

Contact Information

For questions about MCC's risk adjustment programs, please contact your MCC provider services representative.