Provider Manual (Provider Handbook)

Molina Healthcare of Mississippi, Inc.

(Molina Healthcare or Molina)

Children's Health Insurance Program (CHIP)

2023

MolinaHealthcare.com

Capitalized words or phrases used in this Provider Manual shall have the meaning set forth in your Agreement with Molina Healthcare. "Molina Healthcare" or "Molina" have the same meaning as "Health Plan" in your Agreement. The Provider Manual is customarily updated annually but may be updated more frequently as needed. Providers can access the most current Provider Manual at MolinaHealthcare.com.

Last Updated: 11/2022

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 MolinaHealthcare.com

Contents

Introduction

Molina Healthcare of Mississippi contracts with the state of Mississippi to provide services to beneficiaries of the Children's Health Insurance Program (CHIP). The CHIP program serves eligible members up to the age of 19. For more information about the Mississippi CHIP program, please visit the Mississippi Division of Medicaid website at medicaid.ms.gov/programs/childrens-health-insurance-program-chip/ Molina Healthcare has been providing managed health care services through government-sponsored programs since 1980. Molina Healthcare contracts with state governments and serves as a health plan, providing a wide range of quality health care services to families and individuals who qualify for government-sponsored programs, including Medicaid and the State Children's Health Insurance Program (CHIP). Our mission has remained unchanged—to provide outstanding healthcare to the underserved and to do so as if they were part of our family. Our health care model is simple: to address population health needs, always focusing on the individual characteristics of each state.

As our partner, assisting you is one of our highest priorities. We welcome your feedback and look forward to supporting all your efforts to provide quality care.

Please contact our Provider Services Contact Center at (844) 826-4335 if you need any additional information regarding our policies or any topics provided in this provider manual.

Providers are an essential part of delivering quality care to our members. We value our partnership and appreciate the family-like relationship that you pass on to our members.

Section 1. Contact Information

Provider Services Department

The Provider Services Department handles telephone and written inquiries from Providers regarding address and Tax-ID changes, Provider denied Claims review, contracting, and training. The department has Provider Services Representatives who serve all of Molina's Provider network. Eligibility verifications can be conducted at your convenience via Molina's Provider Portal.

Provider Services	
Address:	Molina Healthcare of Mississippi, Inc. 1020 Highland Colony Parkway Suite 602 Ridgeland, MS 39157
Phone:	(844) 826-4335
Fax:	(844) 303-5188

Member Services Department

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 through Friday 7:30 a.m. to 8:00 p.m., and the second weekend, Saturday and Sunday of each month from 8:00 a.m. to 5:00 p.m. excluding State holidays.

Member Services	
Address:	Molina Healthcare of Mississippi, Inc. 1020 Highland Colony Parkway Suite 602 Ridgeland, MS 39157
Phone:	(844) 809-8438
TTY/TDD:	711 Relay

Claims Department

Molina strongly encourages Participating Providers to submit Claims electronically (via a clearinghouse or Molina's Provider Portal).

Access the Provider Portal (provider.MolinaHealthcare.com)
EDI Payer ID: 77010.

To verify the status of your Claim, please use Molina's Provider Portal. For other Claims questions contact Provider Services at the number listed below.

Phone: (844) 826-4335

Claims Recovery Department

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

Claims Recovery	
Phone:	(844) 826-4335

Compliance and Fraud AlertLine

If you suspect cases of fraud, waste, or abuse, you must report it to Molina. You may do so by contacting the Molina Healthcare AlertLine or submit an electronic complaint using the website listed below. For more information about fraud, waste and abuse, please see the Compliance Section of this Manual.

Molina Healthcare AlertLine	
Phone:	(866) 606-3889
Website:	**MolinaHealthcare.alertline.com**

Nurse Advice Line

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

Nurse Advice Line (HEALTHLINE) 24 hours per day, 365 days per year	
English Phone:	(844) 794-3638
TTY/TDD:	711 Relay

Healthcare Services (HCS) Department

The Healthcare Services Department conducts inpatient review on inpatient cases and processes Prior Authorizations/Service Requests. The HCS Department also performs Case Management for Members who will benefit from Case Management services. Participating Providers are strongly encouraged to interact with Molina's HCS Department electronically whenever possible. Prior Authorizations/Service Requests and status checks can be easily managed electronically.

Managing Prior Authorizations/Service Requests electronically provides many benefits to Providers, such as:

- Easy to access 24/7 online submission and status checks
- Ensures HIPAA compliance
- Ability to receive real-time authorization status
- Ability to upload medical records
- Increased efficiencies through reduced telephonic interactions
- Reduces cost associated with fax and telephonic interactions

Molina offers the following electronic Prior Authorizations/Service Requests submission options:

- Submit requests directly to Molina via the Provider Portal. See our 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 our website for guidance.

Healthcare Services Authorizations & Inpatient Census	
Provider Portal: Provider.MolinaHealthcare.com	
Address:	Molina Healthcare of Mississippi, Inc. 1020 Highland Colony Parkway Suite 602 Ridgeland, MS 39157
Phone:	(844) 826-4335
Fax Non- Inpatient:	(844) 207-1620
Fax Inpatient Requests:	(844) 207-1622

Health Management (Health Education/Disease Management)

Molina's Health Management includes Health Education such as weight management, maternity program, smoking cessation, and Disease Management materials, interventions and programs. These services can be incorporated into the Member's treatment plan to address the Member's health care needs.

Weight Management and Smoking Cessations Programs	
Phone:	(866)-472-9483

Health Management/Disease Management and Maternity Programs	
Phone:	(866) 891-2320

Behavioral Health

Molina manages all components of our Covered Services for behavioral health. For Member behavioral health needs, please contact us directly at:

Behavioral Health	
Address:	Molina Healthcare of Mississippi, Inc. 1020 Highland Colony Parkway Suite 602 Ridgeland, MS 39157
Phone:	(844) 826-4335
24 hours per day, 365 days per year:	(844) 794-3638
Fax Inpatient:	(844) 207-1622
Fax Non-Inpatient:	(844) 206-4006

Single Pharmacy Benefit Administrator (SPBA)

Molina Healthcare of Mississippi is not required to cover pharmacy services other than the limited pharmacy services described in this manual including Physician Administered Drugs (PAD). All other pharmacy benefits are covered by DOM's single pharmacy benefit administrator (SPBA), Gainwell Technologies. Gainwell Technologies is responsible for all pharmacy prior authorizations, claims processing, and manages the network pharmacies.

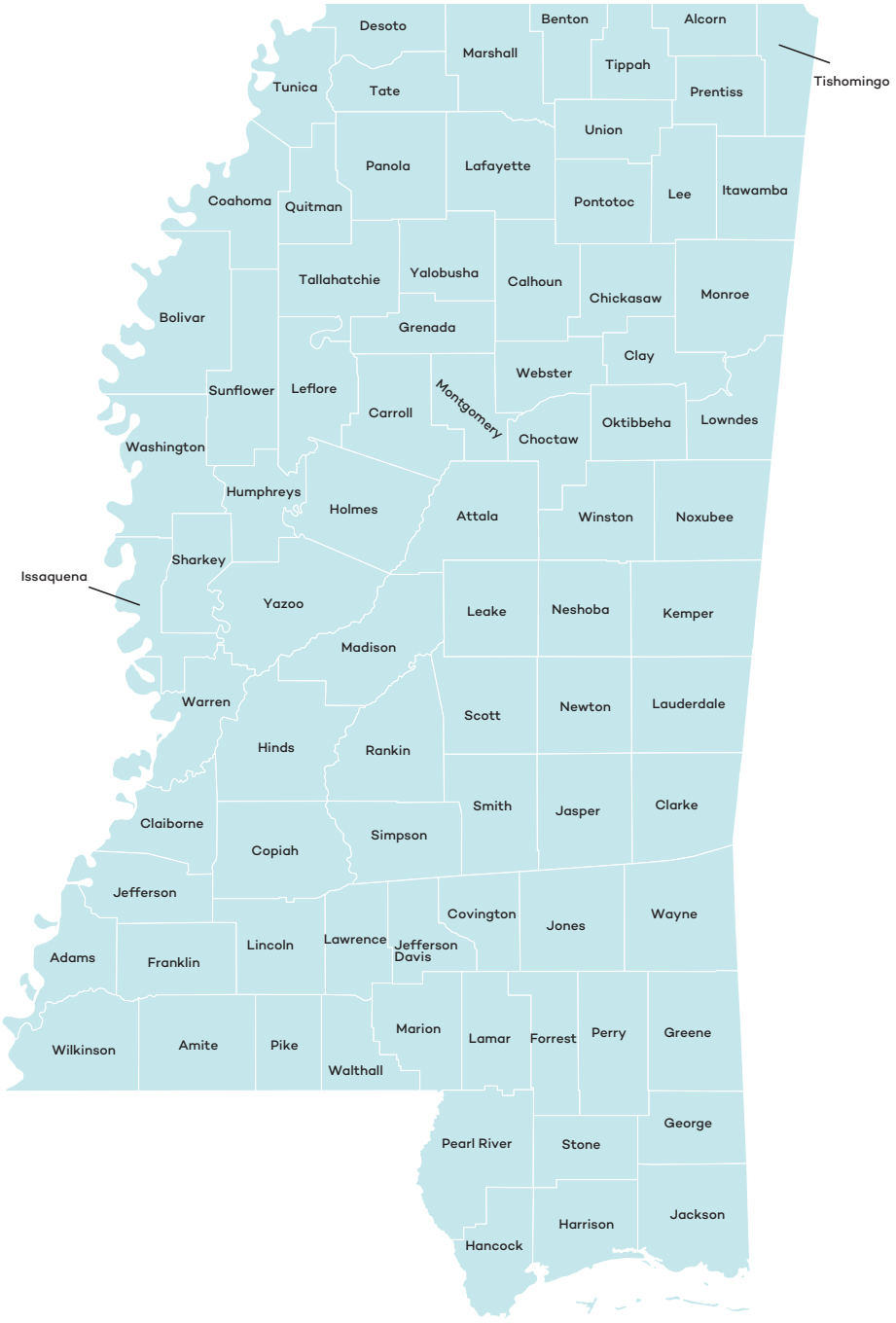
Single Pharmacy Benefit Administrator (SPBA)	
Pharmacy Claims and Prior Authorization Call Center number:	(833) 660-2402
Pharmacy Prior Authorization Fax Number	
Fax:	(866) 644-6147
For more information about the SPBA, please visit medicaid.ms.gov/pharmacy.	

Quality Department

Molina maintains a Quality Department to work with Members and Providers in administering Molina's Quality Programs.

Quality Department	
Phone:	(844) 826-4335

Molina Service Area



Section 2. Provider Responsibilities

Nondiscrimination in Healthcare 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.

Molina requires Providers to deliver services to Molina Members without regard to race, color, national origin, age, disability, religion, genetic information, military status, ancestry, health status, or sex, or need for health services. This includes gender identity, sexual orientation, pregnancy and sex stereotyping. Providers must post a non-discrimination notification in a conspicuous location of their office along with translated non-English taglines in the top fifteen (15) languages spoken in the State to ensure Molina Members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred.

Additionally, Participating Providers or contracted medical groups/IPAs may not limit their practices because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high cost-care. Providers must not discriminate against enrollees based on their payment status and cannot refuse to serve Members because they receive assistance from a State CHIP Program.

Section 1557 Investigations

All Molina 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
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802

Toll Free: (866) 606-3889
TTY/TDD: 711

Online: MolinaHealthcare.AlertLine.com
Email: civil.rights@MolinaHealthcare.com

Role of Primary Care Provider (PCP)

The PCP is the manager of the patients' total health care needs. PCPs prescribe and provide routine and preventive medical services, and coordinate all care that is given by Molina's participating specialists and facilities or any other medical facility where patients might seek care (e.g., Emergency Services). The coordination provided by PCPs may include direct provision of primary care; referrals for specialty care and to programs including Disease Management, educational programs, public health agencies, and community resources.

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).

Provider Data Accuracy and Validation

It is important for Providers to ensure Molina has accurate practice and business information. Accurate information allows us to better support and serve our Provider Network and Members.

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 assignments and referrals. Additionally, current information is critical for timely and accurate Claims processing.

Providers must validate their Provider information on file with Molina at least once every 90 days for correctness and completeness. Additionally, in accordance with the terms specified in your Provider Agreement, Providers must notify Molina of any changes, as soon as possible, but at a minimum 30 calendar days in advance of any changes in any Provider information on file with Molina. Changes such as, but not limited to:

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

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

Please visit our Provider Online Directory (POD) at molina.sapphirethreesixtyfive.com//?ci=ms-molina to validate your information.

Providers can make updates through the CAQH portal, or you may submit a full roster that includes the required information above for each health care Provider and/or health care facility in your practice. Providers unable to make updates through the CAQH portal, or roster process, should contact their Provider Services representative for assistance.

Molina 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, etc. Molina also may use a vendor to conduct routine outreach to validate data that impacts its Provider Directory or otherwise impacts its membership or ability to coordinate member care. Providers are required to provide timely responses to such communications.

Molina Electronic Solutions Requirements

Molina strongly encourages Providers to utilize electronic solutions and tools whenever possible.

Molina strongly encourages all contracted Providers to participate in and comply with Molina's Electronic Solution Requirements, which include, but are not limited to, electronic submission of prior authorization requests, prior authorization status inquires, 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 Availity Essentials portal.

Electronic Claims include Claims submitted via a clearinghouse using the EDI process and Claims submitted through the Availity Essentials portal.

Providers entering the network as a Contracted Provider will be encouraged to comply with Molina's Electronic Solution Policy by enrolling for EFT/ERA payments and registering for Availity Essentials portal within thirty (30) days of entering the Molina network.

Molina 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 Molina. Providers must obtain a National Provider Identifier (NPI) and use their NPI in all HIPAA Transactions, including Claims submitted to Molina. Providers may obtain additional information by visiting Molina's HIPAA Resource Center located on our website at MolinaHealthcare.com.

Electronic Solutions/Tools Available to Providers

- Electronic Tools/Solutions available to Molina Providers include:
    - Electronic Claims Submission Options
    - Electronic Payment: Electronic Funds Transfer (EFT) with Electronic Remittance Advice (ERA)

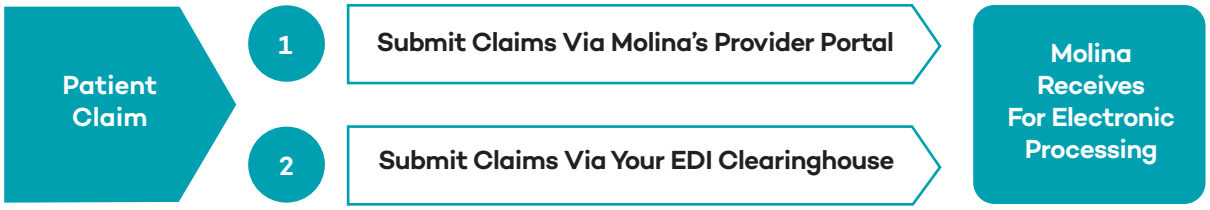
Availity Essentials portal Electronic Claims Submission Requirement

Molina strongly encourages Participating Providers to submit Claims electronically whenever possible. Electronic Claims submission provides significant benefits to the Provider including:

- Promotes HIPAA compliance
- Helps to reduce operational costs associated with paper Claims (printing, postage, etc.)
- Increases accuracy of data and efficient information delivery
- Reduces Claim processing delays as errors can be corrected and resubmitted electronically
- Eliminates mailing time and enabling Claims to reach Molina faster

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina via the Availity Essentials portal.
- Submit Claims to Molina through your EDI clearinghouse using Payer ID 77010.



While both options are embraced by Molina, submitting Claims via Availity Essentials portal (available to all Providers at no cost) offer a number of additional Claims processing benefits beyond the possible cost savings achieved from the reduction of high-cost paper Claims.

Availity Essentials portal Electronic Claims submitting benefits include:

- 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/un-submitted Claims on the Molina's Provider Portal
- Create/Manage Claim Templates (available on Molina's Provider Portal)

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

Electronic Payment Requirement

Participating Providers are strongly encouraged to enroll in Electronic Funds Transfer (EFT) and Electronic Remittance Advice (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 are not required to be in-network to enroll. Molina 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 Molina's website at MolinaHealthcare.com.

Providers are strongly encouraged to register for and utilize Availity Essentials portal Availity Essentials portal is an easy to use, online tool available to all of our Providers at no cost. The Provider Portal offers the following functionality:

- Verify and print Member eligibility
- View benefits, covered services and Member Health Record
- Claims Functions
    - Professional and Institutional Claims (individual or multiple Claims)
    - Receive notification of Claims status change
    - Correct Claims

    - Void Claims
    - Add attachments to previously submitted Claims
    - Check Claims status

- View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP)
    - Export Claims reports
    - Create and Manage Claim Templates
    - Open Saved Claims

- Prior Authorizations/Service Requests
    - Create and submit Service/Prior Authorization Requests
    - Check status of Service/Authorization Requests
    - Receive notification of change in status of Authorization Requests
    - Create Service Request/Authorization Templates

- Appeals
    - Create and submit a Claim Appeal
    - Add Appeal attachment to Appeal
    - Receive email confirmation

Third Party Billers can access and utilize all Claim Functions. Third Party Billers no longer have to phone in to get Claim updates and to make changes. All Claim functionalities are now available for Third Party Billers online at Molina's Provider Portal.

Balance billing

Providers contracted with Molina cannot bill the Member for any Covered Services beyond applicable copayments, deductibles, or coinsurance. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization. We encourage providers to verify eligibility on each date of service

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina to the Provider. Balance billing a Member for services covered by Molina is prohibited. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees.

For additional information please refer to the Compliance and Claims and Compensation sections of this Manual.

Reimbursement of Non-Participating Providers

The Reimbursement Rate for all non-participating providers for Non-Emergent services shall be reduced to fifty percent (50%) of the then current Mississippi Medicaid Fee-For-Service Fee Schedule for those Covered Services, or fifty percent (50%) of the then current Mississippi Medicare Fee Schedule for those Covered Services without a Medicaid Fee Schedule reimbursement value, if accompanied by a valid prior authorization number.

Existing reductions recognized by the Mississippi Division of Medicaid will remain in place.

The Reimbursement Rate for all non-participating providers for Emergency Services shall be one hundred percent (100%) of the then Current Mississippi Medicaid Fee-For-Service Fee Schedule, or one-hundred percent (100%) of the Current Mississippi Medicare Fee Schedule for those Covered Services without a Mississippi Medicaid Fee-For-Service Fee Schedule reimbursement value. Such reimbursement shall be limited to a period of time for the treatment of an Emergency Medical Condition, including Medically Necessary services rendered to the Member until such time as he or she may be safely transported to a network Provider service location. From that time forward, the applicable non-participating provider rate shall apply.

A Member who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the patient.

Member Information and Marketing

Any written informational or marketing materials directed to Molina Members must be developed and distributed in a manner compliant with all State and Federal Laws and regulations and approved by Molina and the Division of Medicaid prior to use. Please contact your Provider Services representative for information and review of proposed materials.

Member Rights and Responsibilities

Providers are required to comply with the Member Rights and Responsibilities as outlined in Molina's Member materials (such as the Member Handbook).

For additional information please refer to the Member Rights and Responsibilities section of this Provider Manual.

Member Cost Share

Providers should verify the Molina Member's cost share status prior to requiring the Molina Member to pay co-pay, co-insurance, 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).

Copayments and Out of Pocket Maximum

A copayment, or copay, is a fee that a CHIP member may need to pay each time his or her child visits their provider or emergency room. There are three coverage plans. Each coverage plan has a different amount that a member will need to pay each time his or her child visits their provider and is based on the member's Federal Poverty Level (FPL). The member's copayment amount is listed on their Molina ID Card

Out-of-Pocket maximum represents the maximum amount a member has to pay out of pocket for copayments each coverage period. A member's coverage period is one (1) year. There are no deductibles or premiums under the CHIP program. There may be a limit to the amount a member has to pay in copays during a coverage period. This amount is the copay maximum. The member

and their PCP will get a letter when the copay maximum is reached. The letter will say that the member does not have to pay any more fees until the end of his or her child's coverage period.

Listed below are the three (3) levels of coverage to indicate the copay or out of pocket maximum for MS CHIP:

Coverage Plan	Provider Visit	Emergency Room Visit	Copay Maximum
MSCHP 01	$0	$0	$0
MSCHP 02	$5 per visit	$15 per visit	$800 per coverage period
MSCHP 03	$5 per visit	$15 per visit	$950 per coverage period

Member Eligibility Verification

Possession of a Molina ID card does not guarantee Member eligibility or coverage. Providers should verify eligibility of Molina Members prior to rendering services. Payment for services rendered is based on enrollment and benefit eligibility. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

For additional information please refer to the Eligibility, Enrollment, Disenrollment and Grace Period section of this Provider Manual.

HealthCare Services (Utilization Management and Care Management)

Providers are required to participate in and comply with Molina's Utilization Management and Care Management programs, including all policies and procedures regarding Molina's facility admission, prior authorization, and Medical Necessity review determination procedures. Providers will also cooperate with Molina in audits to identify, confirm, and/or assess utilization levels of covered services. For additional information please refer to the HealthCare Services section of this Provider Manual.

In Office Laboratory Tests

Molina'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 are found below .

Claims for tests performed in the physician office, but not listed below will be denied.

Code	Description
80047	Basic Metabolic Panel
80048	Basic Metabolic Panel
80053	Comprehensive Metabolic Panel
81025	Urine Pregnancy Test
82947	Glucose, Quantitative

Code	Description
83655	Lead Screening
83735	Magnesium
84436	Thyroxine, Free
84437	Thyroxine, Requiring Elution
84439	Thyroxine, Free
84443	TSH
85007	Blood Count, Differential, WBC
85008	Blood Smear, Manual Blood Count
85014	Hematocrit
85018	Hemoglobin
85032	Manual Cell Count
85049	Platelet, Automated Count
85060	Peripheral Smear
85095	Bone Marrow ASP only
85102	Bone Marrow Biopsy Core
85535	Iron Stain
85576	Platelet Aggregation, any agent
85610	Prothrombin Time
86308	Herterophile, Mono Test
86580	Tuberculosis
87400	Influenza
87804	Influenza
87807	RSV
87880	Rapid Strep
88305	Pathology
88342	Pathology
81000 - 81005	Urinalysis
82043 - 82044	Urine Microalbumin
82270 - 82272	Blood, Occult
82565 - 82575	Creatinine
85025 - 85027	CBC
86140 - 86141	C Reactive Protein
88150 - 88155	Pathology/Pap Smear
88164 - 88167	Pathology/Pap Smear
88174 - 88175	Pathology/Pap Smear
88312 - 88313	Pathology
88331 - 88332	Pathology Consultation, during surgery

For more information about In-Network Laboratory Providers, please consult the Molina Provider Online Directory at molina.sapphirethreesixtyfive.com//?ci=ms-medicaid&locale=en_us. For testing available through In-Network Laboratory Providers. For a list of In-Network Laboratory Provider patient service centers, please reach out to the In-Network Laboratory Provider.

Specimen collection is allowed in a Provider's office and shall be compensated in accordance with your agreement with Molina and applicable State and Federal billing and payment rules and regulations.

Referrals

A referral may become necessary when a Provider determines medically necessary services are beyond the scope of the PCP's practice or it is 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 in the patient's medical record any referrals that are made. Documentation needs to include the specialty, services requested, and diagnosis for which the referral is being made.

Providers should direct Molina Members to health professionals, hospitals, laboratories, and other facilities and Providers which are contracted and credentialed (if applicable) with Molina. 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 and hospital emergency room. There may be circumstances in which referrals may require an out-of-network Provider. Prior authorization will be required from Molina except in the case of Emergency Services. For additional information please refer to the HealthCare Services section of this Provider Manual.

PCPs are able to refer a Member to an in-network specialist for consultation, treatment, and standing referrals without a referral request to Molina.

Treatment Alternatives and Communication with Members

Molina endorses open Provider-Member communication regarding appropriate treatment alternatives and any follow up care. Molina promotes open discussion between Provider and Members regarding Medically Necessary or appropriate patient care, regardless of covered benefits 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 heal.

Pharmacy Program

Providers are asked to consider prescribing drugs listed on the Mississippi DOM's Preferred Drug List (PDL) located at medicaid.ms.gov/preferred-drug-list/ .

Participation in Quality Programs

Providers are expected to participate in Molina's Quality Programs and collaborate with Molina 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 Record-Keeping Practice Reviews
- 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 Molina Members.

Confidentiality of Member Protected Health Information (PHI) and HIPAA Transactions

Molina requires that Providers respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member protected health information. For additional information, please refer to the Compliance section of this Provider.

Participation in Grievance and Appeals Programs

Providers are required to participate in Molina's Grievance Program and cooperate with Molina 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 and/or statement as needed. This includes the maintenance and retention of Member records for a period of not 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 Complaints, Grievance and Appeals Process section of this Provider Manual.

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 Molina
- Triage appropriately
- Notify Molina of Members who may benefit from Care Management
- Participate in the development of Care Management treatment plans

Non-Exclusivity Requirement

Molina may not enter into a Provider agreement that prohibits the Provider from contracting with another Payer or that prohibits or penalizes Molina for contracting with other Providers. Molina may not require Providers who agree to participate in the CHIP Program to contract with Molina's other lines of business.

Provider Services

Molina's Provider Services department is available to educate, and train contracted providers. Provider Services Representatives act as the liaisons between the Provider community and Molina. Provider education and training is conducted upon entry into the Molina Healthcare of Mississippi provider network and thereafter annually, quarterly, or on an as needed basis. Providers can contact the Provider Services Contact Center at 1-844-826-4335 to locate the Provider Services Representative for their area.

Section 3. Cultural Competency and Linguistic Services

Background

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the US Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina 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 orientation, 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 MolinaHealthcare.com/providers/ms/medicaid/resource/care_diverse.aspx, from your local Provider Services Representative and by calling Molina Provider Services at (844) 826-4335.

Nondiscrimination in Healthcare Service Delivery

Molina complies with Section 1557 of the ACA. As a Provider participating in Molina's Provider Network, you and your staff must also comply with the nondiscrimination provisions and guidance set forth by the Department of Health and Human Services, Office for Civil Rights (HHS-OCR); State law; and Federal program rules, including Section 1557 of the ACA.

You are required to do, at a minimum, the following:

1. You **MAY NOT** limit your practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.
2. You **MUST** post in a conspicuous location in your office, a Nondiscrimination Notice. A sample of the Nondiscrimination Notice that you will post can be found in the Member Handbook at MolinaHealthcare.com/members/ms/en-us/mem/medicaid/overvw/handbook.aspx.
3. You **MUST** post in a conspicuous location in your office, a Tagline Document, that explains how to access non-English language services. A sample of the Tagline Document that you will post can be found in the Member Handbook located at MolinaHealthcare.com/members/ms/en-us/mem/medicaid/overvw/handbook.aspx.
4. If a Molina Member is in need of language assistance services while at your office, and you are a recipient of Federal Financial Assistance, you **MUST** take reasonable steps to make your services accessible to persons with limited English proficiency ("LEP"). You can

find resources on meeting your LEP obligations at https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html.

5. If a Molina Member complains of discrimination, you MUST provide them with the following information so that they may file a complaint with Molina's Civil Rights Coordinator or the HHS-OCR:

Civil Rights Coordinator Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802 Phone (866) 606-3889 TTY/TDD, 711 civil.rights@MolinaHealthcare.com	Office of Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 Website: ocrportal.hhs.gov/ocr/smartscreen/main.jsf

If you or a Molina Member needs additional help or more information, call (800) 368-1019 or TTY/TDD (800) 537-7697.

Cultural Competency

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

Provider and Community Training

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

- Training modules, delivered through a variety of methods, include:
- Written materials;
- On-site cultural competency training;
- Online cultural competency Provider training; and
- Integration of cultural competency concepts and nondiscrimination of service delivery into Provider communications

Integrated Quality Improvement – Ensuring Access

Molina ensures Member access to language services such as oral interpretation, American Sign

Language (ASL), and written translation. Molina must also ensure access to programs, aids, and services that are congruent with cultural norms. Molina supports Members with disabilities and assists Members with LEP.

Molina 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 print), leading to better communication, understanding and Member satisfaction. Online materials found on MolinaHealthcare.com 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 Molina Member website.

Access to Interpreter Services

Providers may request interpreters for Members whose primary language is other than English by calling Molina's Contact Center toll free at (844) 826-4335. If Contact Center Representatives are unable to interpret in the requested language, the Representative will immediately connect you and the Member to a qualified language service provider.

Molina 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 Molina Members interpreter services if the Members do not request them on their own. Please remember it is never permissible to ask a family member, friend or individual under the age of 21 (Mississippi Code 1-3-27) to interpret.

Documentation

As a contracted Molina Provider, your responsibilities for documenting Member language services/ 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 Molina.
- Document all Member requests for interpreter services.
- Document who provided the interpreter service. This includes the name of Molina'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

Molina provides a TTY/TDD connection accessible by dialing 711. This connection provides access to Member & Provider Contact Center (M&PCC), Quality, HealthCare Services and all other health plan functions.

Molina strongly recommends that Provider offices make available assistive listening devices 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.

Molina will provide face-to-face service delivery for ASL to support our members who are deaf or hard of hearing. Requests should be made three (3) business days in advance of an appointment to ensure availability of the service. In most cases, Members will have made this request via Molina Member Services.

Nurse Advice Line

Molina provides twenty-four (24) hours/seven (7) days a week Nurse Advice services for Members. The Nurse Advice Line provides access to twenty-four (24) hour interpretive services. Members may call Molina's Nurse Advice Line directly at (844) 794-3638, TTY/TDD 711. The Nurse Advice Line telephone numbers are also printed on membership cards.

Program and Policy Review Guidelines

Molina 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® results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

Section 4. Member Rights and Responsibilities

Providers must comply with the rights and responsibilities of Molina Members as outlined in the Member Handbook and on the Molina website at Member Handbook (MolinaHealthcare.com) The Member Handbook that is provided to Members is hereby incorporated into this Provider Manual.

The most current Member Rights and Responsibilities can be accessed via the following link: MolinaHealthcare.com/members/ms/en-us/mem/medicaid/overvw/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 Molina at (844) 826-4335, TTY/TDD 711, Monday through Friday 7:30 a.m. to 5:30 p.m.

Second opinions

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

Section 5. Enrollment, Eligibility and Disenrollment

Enrollment

Enrollment in CHIP Programs

The Mississippi Division of Medicaid (DOM) administers the CHIP program. DOM determines Member eligibility and oversees Member enrollment into a health plan.

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

Each Member shall be enrolled on the first calendar day of the first calendar month and is automatically renewed for twelve (12) months unless the Member becomes ineligible for the program and is disenrolled.

Newborn Enrollment

The Mississippi Division of Medicaid will only retroactively enroll newborns in the categories of eligibility containing children under one (1).

Inpatient at time of Enrollment

If a Molina Member opts out of or otherwise loses Molina coverage, but is in the hospital on the last day of coverage and the stay continues into the next month, Molina will be responsible for payment of the inpatient Claim for the entire stay based on DOM guidelines. However, if the individual is no longer eligible for Mississippi CHIP inpatient hospital benefits, Molina will not pay for inpatient hospital services beyond the end of CHIP eligibility.

Eligibility Verification

CHIP Programs

The State of Mississippi, through DOM determines eligibility for the CHIP Programs. Payment for services rendered is based on eligibility and benefit entitlement. The Contractual Agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

Eligibility Listing for CHIP Programs

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

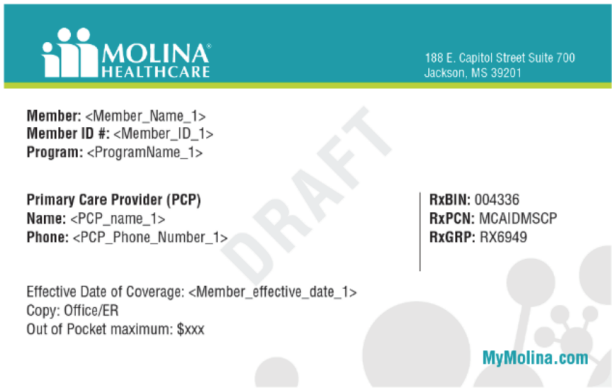
- Molina Provider Services at (844) 826-4335
- Molina Provider Portal provider.MolinaHealthcare.com/

Possession of a Medicaid ID Card does not mean a recipient is eligible for CHIP 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

Molina Sample Member ID card

Card Front



Card Back

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

Disenrollment

Voluntary Disenrollment

Members may change Contractor selection once within the first ninety (90) days of Enrollment and thereafter during open enrollment periods.

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

Involuntary Disenrollment

A Member must be disenrolled from Molina if the Member:

1. No longer resides in the State of Mississippi;
2 .Is identified as pregnant and verified by the Division;
3. Is determined to have Creditable Coverage by the Division;
4. Is deceased; or
5. Becomes a Custodial Nursing Home resident.

PCP Dismissal

A PCP may dismiss a Member from his/her practice based on standard policies established by the PCP. Reasons for dismissal must be documented by the PCP and may include:

For a Member who continues not to comply with a recommended plan of health care. Such requests must be submitted at least sixty (60) calendar days prior to the requested effective date.

For a Member whose behavior is disruptive, unruly, abusive or uncooperative to the extent that the behavior seriously impairs the organization's ability to furnish services to either the Member or other Members.

This section does not apply to Members with mental health diagnoses if the Member's behavior is attributable to the mental illness.

Missed Appointments

Participating Providers are responsible for establishing a process for documenting missed appointments. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record and the Provider is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the medical record. If a second appointment is missed, the Provider should notify Molina Provider Services at: (844) 826-4335.

PCP Assignment

Molina Members are encouraged to choose their own PCPs upon enrollment. If the Member or his or her designated representative does not choose a PCP, one will be assigned within sixty (60) days of Enrollment. Molina will take into consideration known factors such as current Provider relationships, language needs (to the extent they are known), age and sex, enrollment of family members (e.g., siblings), and area of residence.

Assigning a Member an Alternate PCP

If an alternate PCP must be assigned to a member, he or she must call Member Services to ask for the change. The provider can assist the member by accessing the Request to Change Primary Care Provider Form on our website. PCP changes are permitted every 30 days, if needed. If the request is received on or before the 15th of the month, the change will be effective the first day of the next month. If the change request is received after the 15th of the month, the change will be

effective on the first day of the second month following the request. A New ID card is sent to the Member when a PCP change is made.

Specialists as PCPs

Members with disabling conditions, chronic illnesses, or child(ren) with special health care needs may request that their PCP be a specialist. The designation of a specialist as a PCP must be pursuant to a treatment plan approved by Molina; in consultation with the PCP to which the Member is currently assigned, the Member and, as appropriate, the specialist. The PCP and/or specialist must submit a Prior Authorization/Service Request Form (SRF) including the treatment plan for review. When possible, the specialist must be a Provider participating in Molina's network.

The specialist as a PCP must agree to provide or arrange for all primary care, including routine preventive care, and to provide those specialty medical services consistent with the Member's disabling condition, chronic illness, or special health care need in accordance with Molina's standards and within the scope of the specialty training and clinical expertise. In order to accommodate the full spectrum of care, the specialist serving as PCP must also have admitting privileges at a hospital in Molina's network.

PCP Changes

If for any reason a Member wants to change PCPs, he or she must call Member Services to ask for the change. PCP changes are permitted every 30 days, if needed. If the request is received on or before the 15th of the month, the change will be effective the first day of the next month. If the change request is received after the 15th of the month, the change will be effective on the first day of the second month following the request. A New ID card is sent to the Member when a PCP change is made.

Section 6. Benefits and Covered Services

This section provides an overview of the medical benefits and Covered Services for Molina CHIP Program Members. Some benefits may have limitations. If there are questions as to whether a service is covered or requires Prior Authorization please contact Molina at (844) 826-4335 Monday through Friday, 7:30 a.m. to 5:30 p.m. except State holidays.

CHIP Program

Service Covered by Molina

Molina 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 Molina at (844) 826-4335 Monday through Friday, 7:30 a.m. to 5:30 p.m. except State holidays.

Link(s) to Summary of Benefits

The following web link provides access to the Summary of Benefits guides for the CHIP Program offered by Molina in Mississippi.

MolinaHealthcare.com/members/ms/en-us/mem/chip/overvw/coverd/benefits.aspx

Psychiatric Residential Treatment Facilities (PRTF)

PRTFs provide residential services for children under twenty-one (21) years of age. The goal of PRTF treatment is to help the child reach a level of functioning where less restrictive treatment will be possible.

Prior Authorization is required for PRTF treatment (see the Healthcare Services section of this Manual for more information on Prior Authorization guidelines and procedures). Services are billed using Revenue code 1001.

The need for PRTF admission must be supported by documentation that:

- The child has a diagnosable psychiatric disorder.
- The child can participate and process information as evidenced by an appropriate IQ for the program to which they have been admitted, unless there is substantial evidence that the IQ score is suppressed due to psychiatric illness.
- The child's psychiatric symptoms are severe enough to warrant residential treatment under the direction of a psychiatrist.
- The referring psychiatrist or psychologist advised that residential treatment is needed.
- At least one (1) of the following:
    - The child has failed to respond to less restrictive treatment in the last three (3) months.
    - Adequate less restrictive options are not available in the child's community.
    - The child is currently in an acute care facility whose professional staff advise that residential treatment is needed.

Obtaining Access to Certain Covered Services

Durable Medical Equipment (DME)

DME may require Prior Authorization. Only medical supplies, equipment and appliances ordered by a physician are covered and reimbursed under the CHIP program. Effective September 1, 2018, claims for medical supplies and equipment and appliances submitted on a CMS 1500 Form without an applicable physician identifier number and/or ordered by non-physician practitioners will not be covered and payment will be denied.

Prescription Drugs and Over the Counter Medications

Prescription drugs are covered by Molina in alignment with requirements found in the Social Security Act Section 1927 and all changes made to the Covered Outpatient Drug Section of the Patient Protection and Affordable Care Act found in 42.C.F.R. Part 447 {CMS 2345-FC} and subsequent coverage by the Mississippi Division of Medicaid. The Preferred Drug List (PDL) is located at medicaid.ms.gov/preferred-drug-list/. A list of in-network pharmacies is available on the Molina website or by contacting Molina. Members must use their Molina ID card to get prescriptions filled. Additional information regarding the pharmacy benefits is available by contacting Molina at (844) 826-4335.

Clinician Administered Drugs and Implantable Drug System Devices (CADD)

Certain PADs are currently referred to as Clinician Administered Drug and Implantable Drug System Devices (CADDs) and include, but are not limited to, long-acting reversible contraceptives (LARCs), injectable atypical antipsychotic agents, and chemical dependency treatment agents. CADDs may be billed as either medical or pharmacy point of sale to allow greater access to care. Please see medicaid.ms.gov for a complete listing of agents listed under this classification.

CADD drugs will not count toward monthly prescription drug limits applicable to covered outpatient drugs when administered in an outpatient setting.

Prescribers should identify drugs to be billed to a beneficiary's pharmacy benefit (via POS claim) by notating on the prescription that the drug will be administered in an outpatient setting, such as a physician's office.

Billing Directions:

- The pharmacy provider should enter a value of '11' (Office) in NCPDP Field 307-C7
- (Place of Service) to identify that the CADD drug will be administered in a clinician setting and as the mechanism whereby the pharmacy claims processing system will not count the claim toward the prescription monthly limit.

The pharmacy provider should ensure that the CADD drug is routed directly to the prescriber's office. The prescriber should not seek duplicative reimbursement for the drug or drug delivery system on a medical claim. If appropriate, administration or related procedure codes may be submitted on the claim of the provider rendering the applicable service involving the drug or drug delivery system. Please consult the Universal Preferred Drug List (PDL) as some NDCs on the CADD list may be non-preferred and require prior authorization.

Non-Preferred Drug Exception Request Process

The Provider may request a prior authorization for clinically appropriate drugs that are nonpreferred under the Division of Medicaid Universal Preferred Drug List (PDL) or for drugs not on the PDL that also require prior authorization. Molina uses the same prior authorization criteria that are used for FFS drugs included in the PDL which require prior authorization. Molina uses the FDA label, CMS approved compendia, standards of care, and high levels of published clinical evidence for clinical criteria applied to requests for medications requiring prior authorization that are not part of the PDL.

- The Member and/or member's representative and the prescribing provider will be notified of Molina's decision within 24 hours of processing the completed request.
- If the initial request is denied, a notice of denial will be sent in writing to the Member and prescriber within twenty-four (24) hours of receiving the complete request.
- Providers and Members are able to submit a request for reconsideration, and provide additional information pertinent to the clinical need when a denial decision is rendered prior to filing a formal appeal. Requests can be made by calling Molina at (844) 826-4335 or faxing us at (844) 312-6371.
- Members will also have the right to appeal a denial decision, per any requirements set forth by the DOM.
- Molina will allow a seventy-two (72)-hour emergency supply of prescribed medication for dispensing at any time that a prior authorization is not available. Pharmacists will use their professional judgment regarding whether or not there is an immediate need every time the seventy-two (72) hour option is utilized. This procedure will not be allowed for routine and continuous overrides.

Emergency Prescription Supply

A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs requiring a prior authorization (PA), either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits. The 72-hour emergency supply should be dispensed any time a PA cannot be resolved within 24 hours for a medication on the Mississippi Division of Medicaid Preferred Drug List (PDL) that is appropriate for the member's medical condition. If the prescribing provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription.

The pharmacist can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler, as a 72-hour emergency supply. Pharmacists will use their professional judgment regarding whether or not there is an immediate need every time the seventy-two (72) hour option is utilized.

To be reimbursed for a 72-hour emergency prescription supply, pharmacies should submit the following information:

- "8" in "Prior Authorization Type Code" (Field 461-EU)
- "3" in "Days' Supply" (in the Claim segment of the billing transaction (Field 405-D5)
- "11112222333 in "Prior Authorization number" (Field 462-EV)
- The quantity submitted in "Quantity Dispensed" (Field 442-E7) should not exceed the quantity necessary for a 72-hour supply.

Please refer to Section 11 Complaints, Grievance and Appeals Process in this manual for details around appeals for members and providers.

340B Covered Outpatient Drugs

Molina aligns with DOM's policy and reimbursement regarding 340B purchased and administered drugs.

Indian Health Care Services

Molina complies with the provisions of 42 C.F.R. § 438.14 pertaining to reimbursement requirements for Indian Health Care Providers, as defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

Indian Members, meaning any individual as defined by 25 U.S.C. 1603(13), 1603(28), 1679(a), or who has been determined eligible as an Indian under 42 C.F.R. § 136.12, are eligible to receive services from an Indian Health Care Provider Primary Care Provider and choose such a participating network Provider as his or her Primary Care Provider as long as that Provider has the capacity to provide the services.

Indian Members are allowed to obtain Covered Services from an out-of-network Indian Health Care Provider from whom the member is otherwise eligible to receive such services. Additionally, an out-of-network Indian Health Care Provider may refer an Indian Member to a participating network Provider.

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 Molina's Member Contact Center at (844) 809-8438. Molina's Nurse Advice Line is available twenty-four (24) hours a day, seven (7) days a week, 365 days per year for mental health or substance abuse needs. The services Members receive will be confidential. Additional detail regarding Covered Services and limitations can be obtained in the Summary of Benefits linked above, or by contacting Molina.

Emergency Mental Health or Substance Abuse Services

Members are directed to call 988, "911, " or go to the nearest emergency room if they need Emergency Services for mental health or substance abuse. 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

Members can also call the Community Mental Health Centers Crisis Lines which will allow the member to speak to someone immediately and request a team to come to them if needed.

Out of Area Emergencies

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

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

For out-of-area Emergency Services, plans will be made to transfer Members to an in-network facility when 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 in route to the nearest appropriate facility, emergency transportation is thus required. Emergency transportation includes, but is not limited to, ambulance, air or boat transports.

Non-Emergency Medical Transportation

For Molina CHIP Members, non-emergency medical transportation is a value-added service. Molina covers transportation to medical facilities when the Member's medical and physical condition does not allow them to take regular means of public or private transportation (car, bus, etc.). This requires pre-screening by Molina. Examples of non-emergency medical transportation include, but are not limited to, litter vans and wheelchair accessible vans. Members must have prior authorization from Molina for ground and air ambulance services before the services are given. Additional information regarding the availability of this benefit is available by contacting Customer Service at (844) 826-4335.

Preventive Care

Preventive Care Guidelines are located on the Molina website, under the "Provider Resources" tab. Please use the link below to access the most current guidelines:

MolinaHealthcare.com/providers/ms/medicaid/resource/guide_prevent.aspx

We need your help conducting these regular exams in order to meet the targeted State and Federal standards. If you have questions or suggestions related to well child care, please call our Health Education line at (866) 472-9483.

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 and prescribed by the child's PCP.

Immunization schedule recommendations from the American Academy of Pediatrics (AAP) and/or the CDC are available at the following website:

cdc.gov/vaccines/schedules/

Prenatal Care

Stage of Pregnancy	How often to see the doctor
One (1) month – Six (6) months	One (1) visit a month
Seven (7) months – Eight (8) months	Two (2) visits a month
Nine (9) months	One (1) visit a week

Emergency Services

Emergency Services means: Covered inpatient and outpatient services, inclusive of dialysis services, that are furnished by a Provider that is qualified to furnish these services under CHIP and needed to evaluate or stabilize an Emergency Medical Condition.

Emergent and urgent care Services are covered by Molina without an authorization. This includes non-contracted Providers inside or outside of Molina'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 twenty-four (24) hours a day, seven (7) days a week, to assess symptoms and help make good health care decisions.

Nurse Advice Line 24 Hours per day, 365 days per year	
English Phone:	(844) 794-3638
TTY/TDD:	711 Relay

Molina is committed to helping our Members:

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

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

Health Management Programs

The tools and services described here are educational support for Molina Members. We may change them at any time as necessary to meet the needs of Molina Members.

Disease Management

Molina offers programs to help our Members and their families manage a diagnosed health condition.

For more information, please refer to the Health Care Services section of this Provider Manual.

Member Newsletters

Member Newsletters are posted on the MolinaHealthcare.com website at least (two) (2) times a year. The articles are about topics asked by Members. The tips are aimed to help Members stay healthy.

Member Health Education Materials

Members are able to access our easy-to-read materials are about nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, diabetes and other topics. To get these materials, Members are directed to ask their doctor or visit our website.

Program Eligibility Criteria and Referral Source

Health Management Programs are designed for Molina Members with a confirmed diagnosis. Members participate in programs for the duration of their eligibility with the plan's coverage or until the Member opts out. Identified Members will receive targeted outreach such as educational newsletters, telephonic outreach or other materials to access information on their condition. The program model provides an "opt-out" option for Members who contact Molina Member Services and request to be removed from the program.

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

- Pharmacy Claims data for all classifications of medications;
- Encounter Data or paid Claim with a relevant CMS accepted diagnosis or procedure code;
- Member Services welcome calls made by staff to new Member households and incoming Member calls have the potential to identify eligible program participants. Eligible Members are referred to the program registry;
- Member Assessment calls made by staff for the initial Health Risk Assessments (HRA) for newly enrolled Members;
- Provider referral;
- Nurse Advice Line referral;
- Medical Case Management or Utilization Management; and
- Member self-referral due to general plan promotion of program through Member newsletter, the Nurse Advice Line or other Member communication.

Provider Participation

Contracted Providers are notified as appropriate, when their patients are enrolled in a health management program. Provider resources and services may include:

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

Additional information on health management programs is available from your local Molina HCS Department toll free at (844) 826-4335.

Section 7. Healthcare Services (HCS)

Introduction

HealthCare 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. Molina provides care management 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 Molina medical management program include pre-service 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 (UM)

Molina 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. Molina's UM program 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 decision.

Key Functions of the UM Program

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

- **Eligibility and Oversight**
    - Eligibility verification

    - Benefit administration and interpretation
    - Verification that authorized care correlates to Member's medical necessity need(s) & benefit plan
    - Verifying of current Physician/hospital contract status
- **Resource Management**
    - Prior Authorization and referral management
    - Pre-admission, Admission and Inpatient Review
    - Referrals for Discharge Planning and Care Transitions
    - Staff education on consistent application of UM functions
- **Quality Management**
    - Satisfaction evaluation of the UM program using Member and Provider input
    - Utilization data analysis
    - Monitor for possible over- or under-utilization of clinical resources
    - Quality oversight
    - Monitor for adherence to CMS, NCQA, State and health plan UM standards

For more information about Molina's UM program, or to obtain a copy of the HCS Program description clinical criteria used for decision making and how to contact an UM reviewer, access the Molina website or contact the UM Department.

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

UM Decisions

A decision is any determination made by Molina 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);
- Adverse Benefit Determination;
    - Limiting or denying services;
    - Reducing services;
    - Suspending services;
    - Terminating services;
    - Denying payment for services;
    - Failing to provide services in a timely manner;
    - Failing to resolve appeals and grievances within timeliness guidelines;
    - For a resident of a rural area with only one (1) Managed Care Organization in the area, the denial of a request to exercise his or her right to get services outside the Molina network;
    - The denial of a request to dispute a financial responsibility, including cost sharing, co-payments, premiums, deductibles, coinsurance, and other member financial responsibilities; or

- If applicable, decisions by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State about the preadmission screening and annual resident review requirements;
- Discontinuation of a payment or authorization for a service.

Molina follows a hierarchy of medical necessity decision making with Federal and State regulations taking precedence. Molina 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 regulatory requirements and NCQA© standards.

Requests for authorization not meeting criteria are reviewed by a designated Molina Medical Director or other appropriate clinical professional. Only a licensed physician or pharmacist, doctoral level clinical psychologist or certified addiction medicine specialist as appropriate may determine to delay, modify or deny authorization of services to a Member.

Providers can contact Molina's Healthcare Services department at (844) 826-4335 to obtain Molina's UM Criteria.

Where applicable, Molina Corporate Policies can be found on the public website at molinaclinicalpolicy.com/ . Please note that Molina follows state-specific criteria, if available, before applying Molina-specific criteria.

Medical Necessity

Medical Necessity Standards

"**Medically Necessary Services**" or "**Medical Necessity**" means health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. Appropriate and consistent with the diagnosis of the treating Provider and the omission of which could adversely affect the patient's medical condition,
2. Compatible with the standards of acceptable medical practice in the United States,
3. Provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and the severity of the symptoms,
4. Not provided solely for the convenience of the beneficiary or family, or the convenience of any health care Provider,
5. Not primarily custodial care,
6. There is no other effective and more conservative or substantially less costly treatment service and setting available, and
7. The service is not experimental, investigational or cosmetic in nature.

This is for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. Those services must be deemed by Molina 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 are considered effective for the patient's illness, injury or disease; and
3. Not primarily for the convenience of the patient, physician, or other health care Providers. The services must not 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 does not, in itself, make such care, goods or services Medically Necessary, a Medical Necessity or a Covered Service/Benefit.

MCG Cite for Guideline Transparency and MCG Cite AutoAuth

Molina has partnered with MCG Health to implement Cite for Guideline Transparency. Providers can access this feature through the Availity Essentials portal . With MCG Cite for Guideline Transparency, Molina can share clinical indications with Providers. The tool operates as a secure extension of Molina'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 Guideline Transparency does not affect the process for notifying Molina of admissions or for seeking Prior Authorization approval. To learn more about MCG or Cite for Guideline Transparency, visit MCG's website or call (888) 464-4746.

Molina has also partnered with MCG Health, to extend our Cite AutoAuth self-service method for all lines of business to submit advanced imaging prior authorization (PA) requests.

Cite AutoAuth can be accessed via the Availity Essentials portal and is available 24 hours per day/7 days per week. This method of submission is strongly encouraged as your primary submission route, existing fax/phone/email processes will also be available. Clinical information submitted with the PA will be reviewed by Molina. This system will provide quicker and more efficient processing of your authorization request, and the status of the authorization will be available immediately upon completion of your submission.

What is Cite AutoAuth and how does it work?

By attaching the relevant care guideline content to each PA request and sending it directly to Molina, health care providers receive an expedited, often immediate, response. Through a customized rules engine, Cite AutoAuth compares Molina's specific criteria to the clinical

information and attached guideline content to the procedure to determine potential for auto authorization.

Self-services available in the Cite AutoAuth tool include, but are not limited to, MRIs, CTs, PET scans. To see the full list of imaging codes that require PA, refer to the PA code Look-Up Tool at MolinaHealthcare.com.

Medical Necessity Review

Molina only reimburses for services that are medically necessary. Medical necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively. To determine medical necessity, in conjunction with independent professional medical judgment, Molina 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 Molina 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 a medical necessity adverse determination are reviewed by a health care professional at Molina (medical director, pharmacy director, or appropriately licensed health professional).

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

Clinical Information

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

Prior Authorization

Molina requires prior authorization for specified services as long as the requirement complies with Federal or State regulations and the Molina Hospital or Provider Services Agreement. The list of services that require prior authorization is available in narrative form, along with a more detailed list by CPT and HCPCS codes. Molina prior authorization documents are customarily updated quarterly, but may be updated more frequently as appropriate, and are posted on the Molina website at MolinaHealthcare.com/providers/ms/medicaid/forms/fuf.aspx .

Providers are encouraged to use the Molina prior authorization form provided on the Molina web site. If using a different form, the prior authorization request must include the following information:

- Member demographic information (name, date of birth, Molina 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/procedure, including all appropriate CPT and HCPCS.
- Location where service will be performed.
- Clinical information sufficient to document the medical necessity of the requested service is required including:
    - Pertinent medical history (include treatment, diagnostic tests, examination data)
    - Requested length of stay (for inpatient requests)
    - Rational for expedited processing

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. Molina 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. Molina does not retroactively authorize services that require PA.

Molina 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 when the standard time frame or decision making process could seriously jeopardize the life or health of the Member, the health or safety of the Member or others, due to the Member's psychological state, or in the opinion of the Provider with knowledge of the Member's medical or behavioral health condition, would subject the Member to adverse health consequences without the care or treatment that is subject of the request or could jeopardize the Member's ability to regain maximum function. Supporting documentation is required to justify the expedited request.

For expedited organization determinations/pre-service authorization request, Molina will make a determination as promptly as the Member's health requires and no later than twenty-four (24) hours after we receive the initial request for service in the event a Provider indicates, or if we determine that a standard authorization decision timeframe could jeopardize a Member's life or health. For a standard authorization request, Molina makes the determination and provide within three (3) calendar days and/or two (2) business days.

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.

A "peer" is considered a physician, physician assistant, or nurse practitioner, or who is directly providing care to the Member. Contracted external parties, administrators, or facility UM staff can request that a peer-to-peer telephone communication be arranged and performed.

When requesting a peer-to-peer discussion, please be prepared with the following information:

- Member name and ID#
- Auth ID#
- Requesting Provider Name and contact number, best times to call

If a Medical Director is not immediately available, the call will be returned within two business days. Every effort will be made to return calls as expeditiously as possible.

CHIP	
Type of Request	**Decision**
CHIP Routine (Non-urgent) Pre-Service • All necessary information received at time of initial request	Molina will provide a decision within 3 calendar days and/or 2 business days of receipt of request for service. If Molina requires additional medical information in order to make a decision, Molina will notify the requesting Provider of additional medical information needed and Molina will allow three (3) calendar days and/or two (2) business for the requesting Provider to submit the medical information. If Molina does not receive the additional medical information, Molina will make a second attempt to notify the requestor of the additional medical information needed and Molina will allow one (1) business day or three (3) calendar days for the requestor to submit the requested medical information to Molina.
CHIP Routine (Non-urgent) Pre-Service– Extension Needed • Additional clinical information required • Require consultation by an Expert Reviewer • Additional examination or tests to be performed (AKA: Deferral)	Molina may extend time limit an additional fourteen (14) calendar days only where the Member or the Member's provider requests an extension, or the Health Plan/Provider Group can provide justification upon request by the State for the need for additional information and how it is in the Member's best interest.

CHIP	
Type of Request	**Decision**
CHIP - Urgent/Expedited Authorization (Pre-Service) • Requests where provider indicates or the Provider Group /Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function. All necessary information received at time of initial request	Molina must provide decision notice no later than twenty-four (24) hours after receipt of the expedited authorization request. This twenty-four (24) hour period may be extended up to fourteen (14) additional calendar days upon request of the Member, or the Provider, or if Molina requests an extension from the Division. The extension request to the Division applies only after Molina has received all necessary medical information to render a decision and Molina requires additional calendar days to make a decision. The extension request must justify to the Division a need for additional information and explain how the extension is in the Member's best interest. Any such request is subject to Division approval. The Division will evaluate Molina's extension request and notify Molina of decision within three (3) calendar days and/or two (2) business days of receiving Molina's request. Molina must justify to the Division a need for additional information and how the extension is in the Member's best interest.

CHIP	
Type of Request	**Decision**
CHIP -Urgent/Expedited Authorization (Pre-Service) - Extension Needed • Requests where provider indicates or the Provider Group /Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function. Additional clinical information required	Molina must provide decision notice no later than twenty-four (24) hours after receipt of the expedited authorization request. This twenty-four (24) hour period may be extended up to fourteen (14) additional calendar days upon request of the Member, or the Provider, or if Molina requests an extension from the Division. The extension request to the Division applies only after Molina has received all necessary medical information to render a decision and Molina requires additional calendar days to make a decision. The extension request must justify to the Division a need for additional information and explain how the extension is in the Member's best interest. Any such request is subject to Division approval. The Division will evaluate Molina's extension request and notify Molina of decision within three (3) calendar days and/or two (2) business days of receiving Molina's request. Molina must justify to the Division a need for additional information and how the extension is in the Member's best interest.
CHIP **Inpatient/Concurrent** • Review of treatment regimen already in place– Continued Stay Reviews (i.e., inpatient, ongoing/ambulatory services)	Within twenty-four (24) hours of receipt of the request
CHIP Post-Service / Retrospective Review • Conducted when all necessary information are received at time of request and within sixty (60) days of the service date.	Within 20 business days from receipt or request
CHIP Post-Service - Extension Needed • Additional clinical information required	Decision to defer will be made as soon as the Molina is aware that additional information is required to render a decision.

Providers who request prior authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina has a full-time Medical Director available to discuss Medical Necessity decisions with the requesting Provider at (844) 826-4335.

Referrals: PCPs are able to refer a Member to a contracted specialist for consultation and treatment without a referral request to Molina.

Requesting Prior Authorization

Notwithstanding any provision in the Provider Agreement that requires Provider to obtain a prior authorization directly from Molina, Molina 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 on the MolinaHealthcare.com website:

- Prior Authorization Code Look-up Tool
- Prior Authorization Code Matrix

Availity Essentials portal

Participating Providers are encouraged to use the Molina Provider Portal for prior authorization submissions whenever possible. Instructions for how to submit a prior authorization request are available on the **Availity Essentials portal**. The prior authorization functionality on the **Availity Essentials portal** includes:

Create and submit service/prior authorization requests

Check status of service/authorization requests

Receive notification of change in status of service/authorization requests

Attach medical documentation required for timely medical review and decision making for service/authorization requests

Fax: The Prior Authorization Request Form can be faxed to Molina at: (844) 207-1620 (Outpatient) or (844) 207-1622 (Inpatient).

Phone: Prior authorization requests can be initiated by contacting Molina's Healthcare Services department at (844) 826-4335. It may be necessary to submit additional documentation before the authorization can be processed.

Open Communication about Treatment

Molina prohibits contracted Providers from limiting Provider or Member communication regarding a Member's health care. Providers may freely communicate with, and act as an advocate for their patients. Molina requires provisions within Provider contracts that prohibit solicitation of Members for alternative coverage arrangements for the primary purpose of securing financial gain. No communication regarding treatment options may be represented or construed to expand or revise the scope of benefits under a health plan or insurance contract.

Molina and its contracted Providers may not enter into contracts that interfere with any ethical responsibility or legal right of Providers to discuss information with a Member about the Member's health care. This includes, but is not limited to, treatment options, alternative plans or other coverage arrangements.

Delegated Utilization Management Functions

Molina may delegate UM functions to qualifying Medical Groups/IPAs and delegated entities. They must have the ability to perform the delegated activities and maintain specific delegation criteria in compliance with all current Molina policies and regulatory and certification requirements. For more information about delegated UM functions and the oversight of such delegation, please refer to the Delegation section of this Provider Manual.

Communication and Availability to Members and Providers

During business hours HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff by calling (844) 826-4335 during normal business hours, Monday through Friday (except for holidays) from 7:30 a.m. to 6:00 p.m. All staff Members identify themselves by providing their first name, job title, and organization.

Molina offers TTY/TDD services for Members who are deaf, hard of hearing, or speech impaired. Language assistance is also always available for Members.

After business hours, Providers can also utilize fax and the Availity Essentials portal for UM access.

Molina's Nurse Advice Line is available to Members 24 hours a day, seven days a week at (888) 275-8750. Molina's Nurse Advice Line may handle after-hours UM calls.

Emergency Services

Emergency Services means: Covered inpatient and outpatient services, inclusive of dialysis services that are furnished by a Provider that is qualified to furnish these services under CHIP and needed to evaluate or stabilize an Emergency Medical Condition.

Emergency Medical Condition or Emergency means: 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 (i) 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, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

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

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

Molina also provides Members a (24) hour Nurse Advise 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: Molina 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. Services provided after stabilization in a non-participating facility are not covered and the Member will be responsible for payment.

Members over-utilizing the emergency department will be contacted by Molina 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 are not accessing the emergency department because of an inability to be seen by the PCP.

Inpatient Management

Elective Inpatient Admissions

Molina requires prior authorization for all elective/scheduled inpatient admissions and procedures to any facility. Facilities are required to also notify Molina 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.

Emergent Inpatient Admissions

Molina 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. Molina 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.

Inpatient at time of Termination of Coverage

If a Member's coverage with Molina terminates during a hospital stay, all services received after their termination of eligibility are not Covered Services, unless Law or Government Program requirements mandate otherwise.

Inpatient/Concurrent Review

Molina 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 inpatient facilities. Molina will request updated clinical records from inpatient facilities at regular intervals during a Member's inpatient stay. Molina requires that requested clinical information updates be received by Molina from the inpatient facility within (24) hours of the request.

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

Molina will authorize hospital care as an inpatient, when the clinical record supports the medical necessity for the need for continued hospital stay. It is the expectation 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 Molina with a copy of Member's discharge summary to include demographic information, date of discharge, discharge plan and instructions, and disposition.

Inpatient Status Determinations

Molina's UM staff follow CMS guidelines 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 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.

UM staff work closely with the hospital 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 Molina's Quality Improvement Program to ensure that Molina Members are receiving hospital care that is compliant with nationally recognized guidelines as well as Federal and State regulations.

Molina 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.

A Readmission is considered potentially preventable if it is 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 was not completed.
- Behavioral Health readmissions.
- Transplant related readmissions.

Non-Network Providers and Services

Molina requires Members to receive medical care within the participating, contracted network of Providers unless it is for Emergency Services as defined by Federal Law. If there is a need to go to a non-contracted Provider, all care provided by non-contracted, non-network Providers must be prior authorized by Molina. Non-network Providers may provide Emergency Services for a Member who is temporarily outside the service area, without prior authorization or as otherwise required by Federal or State Laws or regulations.

"Emergency Services" means Covered inpatient and outpatient services, inclusive of dialysis services, that are furnished by a Provider that is qualified to furnish these services under Medicaid and needed to evaluate or stabilize an Emergency Medical Condition.

Post Service Review

Failure to obtain authorization when required will result in denial of payment for those services. The only possible exception for payment as a result of post-service review is if information is received indicating the Provider did not know nor reasonably could have known that patient was a Molina Member or there was a Molina error, a Medical Necessity review will be performed. 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.

Specific Federal or State requirements or Provider contracts that prohibit administrative denials supersede this policy.

Affirmative Statement about Incentives

All medical decisions are coordinated and rendered by qualified physicians and licensed staff unhindered by fiscal or administrative concerns. Molina and its delegated contractors do not use incentive arrangements to reward the restriction of medical care to Members.

Molina 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. Molina does not specifically reward Practitioners or other individuals for issuing denials of coverage or care. And, Molina does not receive financial incentives or other types of compensation to encourage decisions that result in underutilization.

Out of Network Providers and Services

Molina requires Members to receive medical care within the participating, contracted network of Providers unless it is for Emergency Services as defined by Federal Law. If there is a need to go to a non-contracted Provider, all care provided by non-contracted, non-network Providers must be prior authorized by Molina. Non-network Providers may provide Emergency Services for a Member

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

Avoiding Conflict of Interest

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

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

Coordination of Care and Services

Molina HCS staff work with Providers to assist with coordinating referrals, services and benefits for Members who have been identified for Molina'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 Molina Members, as necessary, in transitioning to other care when benefits end.

Molina 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 Molina staff is done in partnership with Providers, Members and/or their authorized representative(s) to ensure efforts are efficient and non-duplicative.

There are two (2) main coordination of care processes for Molina Members. The first occurs when a new Member enrolls in Molina and needs to transition current medical care to Molina contracted Providers. Mechanisms within the enrollment process identify the Members and the Member & Provider Contact Center (M&PCC) to assist in obtaining authorizations, transferring to contracted DME vendors, receiving approval for prescription medications, etc. The second coordination of care process occurs when a Molina Member's benefits will be ending, and they need assistance in transitioning to other care. The process includes mechanisms for identifying Molina Members whose benefits are ending and are in need of continued care.

Continuity of Care and Transition of Members

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

Provider that has 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 ninety (90) days or longer if necessary, for a safe transfer to another Provider as determined by Molina or its delegated Medical Group/IPA.
- 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 Molina at (844) 826-4335.

Reporting of Suspected Abuse and/or Neglect

A vulnerable adult is a person who is 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 themselves 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:

The Mississippi Abuse, Neglect, and Exploitation Reporting System, Centralized Intake, Department of Human Services:

(800) 222-8000

Adult Abuse:

Mississippi Department of Human Services:

(844) 437-6282

Molina's HCS teams will work with PCPs and Medical Groups/IPA and other delegated entities who are obligated to communicate with each other when there is 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.

Molina will follow up with Members that are reported to have been abused, exploited or neglected to ensure appropriate measures were taken, and follow up on safety issues. Molina will track, analyze, and report aggregate information regarding abuse reporting to the HealthCare Services Committee and the proper State agency.

Care Management (CM)

The CM program focuses on procuring and coordinating the care, services, and resources needed by Members with complex needs through a continuum of care. Molina adheres to Case Management Society of America Standards of Practice Guidelines in its execution of the program.

The Molina care managers are licensed professionals and are educated, trained and experienced in the care management process. The CM program is based on a Member advocacy philosophy, designed and administered to assure the Member value-added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes. The CM program is individualized to accommodate a Member's needs with collaboration from the Member's PCP. The Molina care manager will arrange individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina care manager is responsible for assessing the Member's appropriateness for the CM program and making a recommendation for a treatment plan.

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

Members with the following conditions could benefit from care management and should be referred to the Molina CM Program for evaluation:

- High-risk pregnancy, including Members with a history of a previous preterm delivery
- Catastrophic medical conditions (e.g. neoplasm, organ/tissue transplants)
- Chronic illness (e.g. asthma, diabetes, End Stage Renal Disease)
- Serious and Persistent Mental Illness and Substance Use Disorders
- Preterm births
- High-technology home care requiring more than two weeks of treatment
- Member accessing ER services inappropriately

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

Phone: (844) 826-4335
Fax: (844) 206-0435

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 individualized care plan (ICP), interdisciplinary care team (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 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 Members' needs warrant care management.
- Monitors and communicates the progress of the implemented plan of care to all involved resources.
- Serves as a coordinator and resource to the health care team throughout the implementation of the plan, and revises the plan as suggested and needed.
- Coordinates appropriate education and encourages the Member's role in self-help.
- Monitors progress toward the Member's achievement of treatment plan goals in order to determine an appropriate time for the Member's discharge from the CM program.

Health Management

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

Molina 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 additional education and support Molina offers. Members can request to be enrolled or dis-enrolled in these programs at any time. Our Molina My Health programs include:

- Living with Asthma
- Living with Diabetes
- Living with High Blood Pressure

- Living with Heart Failure (HF)
- Living with COPD
- Living with Depression
- Weight Management
- Tobacco Cessation
- Nutrition

Maternity Screening and High Risk Obstetrics

Molina 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 Molina, member self-referral and internal Molina notification processes. Providers can notify Molina of pregnant/ high risk pregnant members via faxed Pregnancy Notification Report Forms.

Pregnancy Notification Process

The PCP shall submit to Molina the Pregnancy Notification Report Form (available at https://www.MolinaHealthcare.com/providers/ms/medicaid/forms/~/media/Molina/PublicWebsite/PDF/Providers/ms/medicaid/CHIP-Pregnancy-Notification-Report-Form_191002_R.pdf) within one (1) working day of the first prenatal visit and/or positive pregnancy test. The form should be faxed to Molina at (844) 206-0435.

Member Newsletters

Member Newsletters are posted on the MolinaHealthcare.com website at least once a year. The articles are about topics 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 Molina Members with a confirmed diagnosis. Identified Members will receive targeted outreach such as educational materials , telephonic outreach or other materials to access information on their condition. Members can contact Molina 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 have 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 Nurse Advice Line, Medication Management or Utilization Management.
- Member self-referral due to general plan promotion of program through Member newsletter, or other Member communications.

Provider Participation

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 Health Management Programs, including how to enroll patients and outcomes of the programs;
- Clinical Practice Guidelines
- Preventive Health Guidelines
- Case Management collaboration with the Member's Provider
- Faxing a Provider Collaboration Form to the Member's Provider when indicated

Additional information on Health Management Programs is available from your local Molina Healthcare Services Department toll free at (844) 826-4335.

Primary Care Providers

Molina 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 Molina. Molina's Members are required to see a PCP who is part of the Molina Network. Molina's Members may select or change their PCP by contacting Molina's Member & Provider Contact Center.

Specialty Providers

Molina 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.

Molina 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 Molina UM department. Referrals to specialty care outside the network require prior authorization from Molina.

ICM Program

Molina 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. Molina adheres to Case Management Society of America Standards of Practice Guidelines in its execution of the program.

The Molina care managers may be licensed professionals and are educated, trained and experienced in Molina'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 Molina 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 Molina care manager is responsible for assessing the Member's appropriateness for the ICM program and for notifying the PCP of facilitating and assisting with the development of the Member's ICP.

Members with high-risk medical conditions and/or other care needs may be referred by their PCP or specialty care Provider to the ICM 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 Molina 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 Molina at:

Phone: 1-844-826-4335
Fax: 1-844-206-0435

Section 8. Behavioral Health

Overview

Molina provides a Behavioral Health benefit for Members. Molina 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 Molina's Prior Authorization team at (844) 826-4335.. Providers requesting after-hours authorization for these services should utilize Availity Essentials 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. Molina 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.

Behavioral Health Providers may refer a Member to an in-network PCP, or a Member may self-refer. Members may be referred to a PCP and specialty care Providers to manage their health care needs. 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, Molina 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. Molina's Care Management program may assist in coordinating care and communication amongst all Providers of a Member's treatment team.

Care Management

Molina'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 Molina at:

Phone: (844) 826-4335
Fax:(844) 206-0435

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

Molina 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 Molina 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. Molina 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

Molina 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 (844)-809-8438.

National Suicide Lifeline

988 is the National Suicide Lifeline. Anyone in need of suicide or mental health crisis support (or anyone worried about someone else), can receive free and confidential support 24 hours a day,

7 days a week, 365 days per year, by dialing 988 from any phone.

Behavioral Health Tool Kit for Providers

Molina 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.

Section 9. Quality

Maintaining Quality Improvement Processes and Programs

Molina maintains a Quality Department to work with Members and Providers in administering the Molina Quality Improvement Program. You can contact the Molina Quality Department toll free at (844) 826-4335.

The address for mail requests is:

Molina Healthcare of Mississippi, Inc.
Quality Department
1020 Highland Colony Parkway Suite 602
Ridgeland, MS 39157

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

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

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

- Have a QIP in place
- Comply with and participate in Molina's Quality Improvement Program including reporting of Access and Availability survey and 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; and
- Allow access to Molina Quality personnel for site and medical record review processes.

Patient Safety Program

Molina's Patient Safety Program identifies appropriate safety projects and error avoidance for Molina Members in collaboration with their PCPs. Molina continues to support safe personal health practices for our Members through our safety program, pharmaceutical management and case management/disease management programs and education. Molina 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), Health and Human Services (HHS) is to identify areas that have the potential for improving health care quality to reduce the incidence of events.

Quality of Care

Molina has an established and systematic process to identify, investigate, review and report any Quality of Care, Adverse Event/Never Event, Critical Incident (as applicable), and/or service issues

affecting Member care. Molina will research, resolve, track and trend issues. Confirmed Adverse Events/Never Events are reportable when related to an error in medical care that is clearly identifiable, preventable and/or found to have caused serious injury or death to a patient. Some examples of never events include:

- Surgery on the wrong body part.
- Surgery on the wrong patient.
- Wrong surgery on a patient.

Medical Records

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

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

Medical Record Keeping Practices

Below is a list of the minimum items that are 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 twenty-four (24) hours
- If hardcopy, pages are securely attached in the medical record and records are organized by dividers or color-coded when thickness of the record dictates
- If electronic, 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 is a process for release of medical records including behavioral health care records

Content

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

- 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;
- Allergies and adverse reactions (or notation that none are known);
- Documentation that Advanced Directives, Power of Attorney and Living Will have been discussed with member, and a copy of Advance Directives when in place;
- Past medical and surgical history, including physical examinations, treatments, preventive services and risk factors;
- Treatment plans that are 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 are ordered as appropriate by the practitioner;
- 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, included in the next preventative care visit when appropriate;
- Notes from consultants if applicable;
- Up-to-date 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 and physicals and operative report;
- Labor and Delivery Record for any child seen since birth; and,
- 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 retrieval of information; and

A release document for each Member authorizing Molina to release medial information for facilitation of medical care.

Retrieval

- The medical record is available to Provider at each Encounter
- The medical record is available to Molina for purposes of Quality Improvement
- The medical record is available to Mississippi Division of Medicaid 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 twenty-four (24) hours, is consistent with State and Federal requirements, and the record is maintained for not less than then10 years from the last date of treatment or for a minor, one (1) year past their twentieth (20th) birthday, but never less than ten 10 years
- An established and functional data recovery procedure in the event of data loss

Confidentiality

Molina 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 an enrollment information
- Medical Records are protected from unauthorized access
- Access to computerized confidential information is restricted and
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information
- Education and training for all staff on handling and maintain protected health information (PHI)

Additional information on medical records is available from your local Molina Quality department toll free at (844) 826-4335. See also the Compliance Section of this Manual for additional information regarding the Health Insurance Portability and Accountability Act (HIPAA).

Access to Care

Molina maintains access to care standards and processes for ongoing monitoring of access to health care (including behavioral health care) provided by contracted primary PCPs (adult and pediatric) and participating specialist (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 ninety percent (90%) availability for Emergency Services and ninety percent 90 percent or greater for all other services. The PCP or his/her designee must be available twenty-four (24) hours a day, seven days a week to Members.

Appointment Access

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

Medical Appointment Types	Standard
Routine, asymptomatic	Within thirty (30) calendar days
Routine, symptomatic	Within seven (7) calendar days
Urgent Care	Within twenty-four (24) hours
Dental Providers (Urgent Care)	Not to exceed forty-eight (48) hours
Dental Providers (routine visits)	Not to exceed forty-five (45) calendar days
After Hours Care	Twenty-four (24) hours/day; seven (7) day/week availability
Specialty Care (High Volume)	Within forty-five (45) calendar days
Specialty Care (High Impact)	Within forty-five (45) calendar days
Urgent Specialty Care	Within twenty-four (24) hours
Behavioral Health Appointment Types	**Standard**
Life Threatening Emergency	Immediately
Non-life-Threatening Emergency	Within six (6) hours
Urgent Care	Within twenty-four (24) hours
Routine Care	Within seven (7) calendar days
Follow-up Routine Care (post- discharge from an acute psychiatric hospital when the Contractor is aware of the Member's discharge)	Within seven (7) calendar days
Emergency Providers	Immediately (twenty-four (24) hours a day, seven (7) days week) and without Prior Authorization

Additional information on appointment access standards is available from your local Molina Quality Department toll free at (844) 826-4335.

Office Wait Time

For scheduled appointments, the wait time in offices should not exceed forty-five (45) minutes. All PCPs are required to monitor waiting times and adhere to this standard.

After Hours

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

Appointment Scheduling

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

1. The Provider must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments;
2. A process for documenting missed appointments must be established. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record and the Provider is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the medical record. If a second appointment is missed, the Provider is to notify the Molina Provider Services Department toll free at (844) 826-4335, TTY/TDD 711;
3. When the Provider must cancel a scheduled appointment, the Member is given the option of seeing an associate or having the next available appointment time;
4. Special needs of Members must be accommodated when scheduling appointments. This includes, but is not limited to wheelchair-using Members and Members requiring language interpretation;
5. A process for Member notification of preventive care appointments must be established. This includes, but is not limited to immunizations and mammograms; and
6. A process must be established for Member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test results or the scheduling of procedures which must be performed prior to the next visit.

In applying the standards listed above, participating Providers have agreed that they will not discriminate against any Member on the basis of age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental or sensory handicap, gender identity, pregnancy, sex stereotyping, place of residence, socioeconomic status, or status as a recipient of CHIP benefits. Additionally, a participating Provider or contracted medical group/IPA may not limit his/her practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high cost care. If a PCP chooses to close his/her panel to new Members, Molina must receive thirty (30) days advance written notice from the Provider.

Women's Health Access

Molina allows Members the option to seek women's routine and preventive health care from an in-network women's health specialist or directly from a participating PCP designated by Molina as providing women's routine and preventive health care services. Member access to women's routine and preventive health care 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 under the Resources tab on the MolinaHealthcare.com website or from your local Molina Quality Department toll free at (844) 826-4335.

Monitoring Access Standards

Access to care standards are reviewed, revised and necessary, and approved by the Quality Improvement Committee on an annual basis.

- Provider network adherence to access standards is monitored via the following mechanisms:
- Provider access studies – Provider office assessment of appointment availability and after-hours access.
- Member complaint data – assessment of Member complaints related to access to care.

Member satisfaction survey – evaluation of Members' 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 initialized when performance goals are not met and for identified provider specific or organizational trends. Performance goals are reviewed and approved annually by the Quality Improvement Committee.

Quality of Provider Office Sites

Molina Providers are to maintain office-site and medical record keeping practices standards. Molina continually monitors Member complaints and appeals/grievances for all office sites to determine the need of an office site visit and will conduct office site visits as needed. Molina 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

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

Physical appearance

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

Adequacy of waiting and examining room space

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

Administration & Confidentiality of Facilities

Facilities contracted with Molina 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 is 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 10or 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 are not kept in exam rooms.

- Narcotics are locked, preferably double-locked. Medication and sample access is restricted.
- System in place to ensure expired sample medications are not dispensed and injectables and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

Advance Directives (Patient Self-Determination Act)

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

Providers must inform adult Molina Members, eighteen (18) years old and up, of their right to make health care decisions and execute Advance Directives. It is important that Members are informed about Advance Directives.

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 Molina website. If a Member is incapacitated at the time of enrollment, Molina 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.

PCPs must discuss Advance Directives with a Member and provide appropriate medical advice if the Member desires guidance or assistance.

Molina 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. Molina 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 Molina or the State survey and certification agency if the Member is dissatisfied with Molina's handling of Advance Directives and/or if a Provider fails to comply with

Advance Directives instructions.

Molina will notify the Provider of an individual Member's Advance Directives identified through Care Management, Care Coordination or Case Management. Providers are instructed to document the presence of an Advance Directive in a prominent location of the medical record. Auditors will also look for copies of the Advance Directive form. Advance Directives forms are State specific to meet State regulations.

Molina will look for documented evidence of the discussion between the Provider and the Member during routine medical record reviews.

Members have the right to file a complaint or grievance concerning non-compliance with the advance directive requirements with the State Survey and Certification Division of the State Department of Health.

Well Child Services to Enrollees Under Nineteen (19) Years

Molina offers Well Child services through the end of the month in which the Member turns Nineteen (19) years. Molina maintains systematic and robust monitoring mechanisms to ensure all required Well Child Services to Enrollees under nineteen (19) years are timely according to required preventive guidelines. All Enrollees under nineteen (19) years of age should receive preventive, diagnostic and treatment services at intervals as set forth in Section 1905® of the Social Security Act. Molina's Quality Improvement Department is 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.

Participating Providers are responsible for contacting new Members who are not compliant with Well Child periodicity and immunization schedules for children as identified in the quarterly encounter list provided by Molina. Providers should document reasons for noncompliance, where possible, and document efforts to bring the Member's care into compliance with the standards.

Well child / adolescent visits

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

- comprehensive health and developmental history;
- nutritional assessment;
- height and weight and growth charting;
- comprehensive unclothed physical examination;
- appropriate immunizations;
- laboratory procedures, including lead blood level assessment appropriate for age and risk factors;
- periodic developmental and behavioral screening;
- vision and hearing tests;
- dental assessment and services; and
- health education (anticipatory guidance including child development, healthy lifestyles, and 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.

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

Monitoring for Compliance with Standards

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

Quality Improvement Activities and Programs

Molina maintains an active Quality Improvement Program. 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

The Molina Health Management Program provides for the identification, assessment, stratification, and implementation of appropriate interventions for Members with chronic diseases. For additional information, please see the Health Management heading in the Healthcare Services section of this Manual.

Care Management

Molina's Care Management Program involves collaborative processes aimed at meeting an individual's health needs, promoting quality of life, and obtaining best possible care outcomes to meet the Member's needs so they receive the right care, at the right time, and at the right setting. Molina's Care Management includes Health Management (HM) and Case Management (CM) programs. Members may qualify for HM or CM based on confirmed diagnosis or specified criteria for the programs. These comprehensive programs are available for all Members that meet the criteria for services. For additional information please see the Care Management heading in the Healthcare Services section of this Manual.

Clinical Practice Guidelines

Molina 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 annually and are updated as new recommendations are published.

Molina CPGs include the following:

- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Children with Special Health Care Needs
- Diabetes
- Heart Failure in adults
- Homelessness-Special Health Care Needs
- Hypertension
- Obesity
- Opioid
- 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 Molina website. Individual Providers or Members may request copies from the local Molina Quality Department toll free at (844) 826-4335.

Preventive Health Guidelines

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

- Prenatal Care
- 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 with each release by USPSTF and are approved by the Quality Improvement Committee.

On an annual basis, Preventive Health Guidelines are distributed to Providers at MolinaHealthcare.com/providers/ms/medicaid/resource/guide_prevent.aspx and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Provider Newsletter.

Cultural and Linguistic Services

Molina 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 Molina's program and services, please see the Cultural Competency and Linguistic Services section of this Manual.

Measurement of Clinical and Service Quality

Molina 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; and
- Effectiveness of Quality Improvement Initiatives.

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

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

Molina's most recent results can be obtained from your local Molina Quality Department toll free at (844) 826-4335 or by visiting our website at HEDIS (MolinaHealthcare.com) and CAHPS (MolinaHealthcare.com).

Healthcare Effectiveness Data and Information Set (HEDIS)®

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

HEDIS® results are used in a variety of ways. They are the measurement standard for many of Molina'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 are also used to compare to established health plan performance benchmarks.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)®

CAHPS® is the tool used by Molina 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 Molina's quality improvement activities and are used by external agencies to help ascertain the quality of services being delivered.

Behavioral Health Survey

Molina obtains feedback from Members about their experience, needs, and perceptions of accessing behavioral health care services. The 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 Molina, and perceived improvement in their conditions, among other areas.

Provider Satisfaction Survey

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

Effectiveness of Quality Improvement Initiatives

Molina 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, Molina 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; and,
- Be sure patients understand what they need to do.

Molina has additional resources to assist Providers and their patients. For access to tools that can assist, please visit Molina's website and click on Providers. There is a variety of resources, including:

- HEDIS® CPT/CMS-approved diagnostic and procedural code sheets
- A current list of HEDIS® and CAHPS® Star Ratings measures.

Section 10. Compliance

Fraud, Waste, and Abuse

Introduction

Molina is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, Molina's Compliance department maintains a comprehensive plan, which addresses how Molina 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 Molina.

Molina's Special Investigation Unit (SIU) supports Compliance in its efforts to 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

Our mission is to pay claims correctly the first time, and that mission begins with the understanding that we need to proactively detect fraud, waste, and abuse, correct it, and prevent it from reoccurring. Since not all fraud, waste, or abuse can be prevented, Molina employs processes that retrospectively address fraud, waste, or abuse that may have already occurred. Molina strives 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 does not require proof of a specific intent to defraud the U.S. Government. Instead, health care Providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent Claims to the Government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false Claim to be submitted.

Deficit Reduction Act

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

As a contractor doing business with Molina, Providers and their staff have the same obligation to report any actual or suspected violation of CHIP 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 a 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 have been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to their role in disclosing or reporting a false Claim are entitled to all relief necessary to make the employee whole including:

Employment reinstatement at the same level of seniority.

Two times the amount of back pay plus interest.

Compensation for special damages incurred by the employee as a result of the employer's inappropriate actions.

Affected entities who fail to comply with the Law will be at risk of forfeiting all Medicaid payments until compliance is met. Molina will take steps to monitor Molina contracted Providers to ensure compliance with the Law.

Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))

Anti-Kickback Statute ("AKS") is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for CHIP patients). In some industries, it is acceptable to reward those who refer business to you. However, in the Federal health care programs, paying for referrals is a crime. The statute covers the payers of kickbacks-those who offer or pay remuneration- as well as the recipients of kickbacks-those who solicit or receive remuneration.

Molina conducts all business in compliance with Federal and State Anti-Kickback Statutes (AKS) statutes and regulations and Federal and State marketing regulations. Providers are prohibited from engaging in any activities covered under this statute.

What is AKS?

AKS statutes and regulations prohibit paying or receiving anything of value to induce or reward patient referrals or the generation of business involving any item or service payable by Federal and State health care programs. The phrase "anything of value" can mean cash, discounts, gifts, excessive compensation, contracts not at fair market value, etc. Examples of prohibited AKS

actions include a health care Provider who is compensated based on patient volume, or a Provider who offers remuneration to patients to influence them to use their services.

Under Molina's policies, Providers may not offer, solicit an offer, provide, or receive items of value of any kind that are intended to induce referrals of Federal health care program business. Providers must not, directly, or indirectly, make or offer items of value to any third party, for the purpose of obtaining, retaining, or directing our business. This includes giving, favors, preferential hiring, or anything of value to any government official.

Marketing Guidelines and Requirements

Providers must conduct all marketing activities in accordance with the relevant contractual requirements and marketing statutes and regulations – both State and Federal.

Under Molina's policies, Marketing means any communication, to a beneficiary who is not enrolled with Molina, that can reasonably be interpreted as intended to influence the beneficiary to enroll with Molina's CHIP products. This also includes communications that can be interpreted to influence a beneficiary to not enroll in or to disenroll from another Health Plan's products.

Restricted marketing activities vary from state-to-state but generally relate to the types and form of communications that health plans, Providers and others can have with Members and prospective Members. Examples of such communications include those related to enrolling Members, Member outreach, and other types of communications.

Stark Statute – Similar to the Anti-Kickback Statute, but more narrowly defined and applied. It applies specifically to CHIP services provided only by physicians, 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: means an intentional deception or misrepresentation made by a person with themself the knowledge that the deception could result in some unauthorized benefit to 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 CHIP program.

Abuse: means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards

for health care. It also includes recipient practices that result in unnecessary cost to the CHIP programs. (42 CFR § 455.2)

Examples of Fraud, Waste and Abuse by a Provider

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

- A Provider knowingly and willfully referring a Member to health care facilities in which or with which the physician 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 Molina 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 are not Medically Necessary.
- Billing for services, procedures and/or supplies that have not 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 Molina identification card.
- Failing to report a Member's forgery or alteration of a prescription or other medical document.
- False coding in order to receive or maximize reimbursement.
- Inappropriate billing of modifiers in order to receive or maximize reimbursement.
- Inappropriately billing of a procedure that does not 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 that result in higher costs or charges.
- Questionable prescribing practices.
- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code.
- Underutilization, which means failing to provide services that are Medically Necessary.
- Upcoding, which is when a Provider does not 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 Molina include, but are not limited to, the following:

- Benefit sharing with persons not entitled to the Member's benefits.
- Conspiracy to defraud government funded programs like CHIP.
- 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 do not suffer from and the Member sells the medication to someone else.

Review of Provider Claims and Claims System

Molina Claims Examiners are trained to recognize unusual billing practices, which are key in trying to identify fraud, waste and abuse. If the Claims Examiner suspects fraudulent, abusive or wasteful billing practices, the billing practice is documented and reported to the SIU through our Compliance Department.

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

Molina performs auditing to ensure the accuracy of data input into the Claims system. The Claims department conducts regular audits to identify system issues or errors. If errors are identified, they are corrected, and a thorough review of system edits is conducted to detect and locate the source of the errors.

Prepayment Fraud, Waste, and Abuse Detection Activities

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

Molina has a pre-payment 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, Centers for Medicare and Medicaid Services (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 Medical Medically Unlikely Edit table, the Medicaid National Correct Coding Initiative (NCCI) files 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, Molina 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 Manual are incorporated into the Provider Agreement, and are intended to supplement, rather than diminish, any and all other rights and remedies that may be available to Molina under the Provider Agreement or at Law or equity. In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement, the parties agree that Molina shall in its sole discretion exercise the terms that are expressed in the Provider Agreement, the terms that are expressed here, its rights under Law and equity, or some combination thereof.

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

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

Provider acknowledges that HIPAA specifically permits a covered entity, such as Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 154.501). Provider further acknowledges that in order to receive payment from Molina, Provider is required to allow Molina 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

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

Provider acknowledges Molina's right to conduct pre and post-payment billing audits. Provider shall cooperate with Molina's Special Investigations Unit 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 Molina'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, Molina 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 Molina 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. Molina asks that you provide Molina, or Molina'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 Molina's Special Investigations Unit suspects that there is fraudulent or abusive activity, Molina may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Molina reserves the right to recover the full amount paid or due to you.

Provider Education

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

Molina will notify the Provider of the deficiency and will take steps to educate the Provider, which may include the Provider submitting a corrective action plan (CAP) to Molina addressing the issues identified and how it will cure these issues moving forward.

Reporting Fraud, Waste and Abuse

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

Molina 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 MolinaHealthcare.alertline.com

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

Molina Healthcare of Mississippi
Attn: Compliance
1020 Highland Colony Parkway Suite 602
Ridgeland, MS 39157

Remember to include the following information when reporting:

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

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

Mississippi Division of Medicaid
ATTN: Office of Program Integrity
550 High Street, Suite 1000
Jackson, MS 39201

Toll Free Phone: (800) 880-5920 or (601) 576-4162

Fax: (601) 576-4161

Failure to report instances of suspected Fraud and Abuse is a violation of the Law and subject to the penalties provided by Law.

HIPAA Requirements and Information

Molina's Commitment to Patient Privacy

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

Provider Responsibilities

Molina expects that its contracted Provider will respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member PHI. Molina provides its Members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how Molina uses and discloses their PHI and includes a summary of how Molina 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")
- In accordance with 42 CFR § 401.305 and MCL 400.111b(16), CHIP Providers are required to self-report any overpayment received from Molina, return the overpayment to Molina, and notify Molina in writing for the reason of the overpayment. To self-report an overpayment, please see Chapter 4-Claims for more information.

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 is 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)
   - Medicare and Medicaid Laws
   - The Affordable Care Act
   - Title 42 Part 2, substance Use Disorder Confidentiality Regulations
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 is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity1. 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:

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. a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, inpatient review, and retrospective review of "services2."
2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:

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

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

- Quality improvement;
- Disease management;
- Care Management and Care Coordination;
- Training Programs;
- Accreditation, Licensing, and Credentialing

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

Title 42 Part 2, 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 do not allow disclosure without the Member's written consent except as set forth in 42 CFR Part 2.

Inadvertent Disclosures of PHI

Molina may, on occasion, inadvertently misdirect or disclose PHI pertaining to Molina Member(s) who are not the patients of the Provider. In such cases, the Provider shall return or securely destroy the PHI of the affected Molina 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 Molina.

Written Authorizations

Uses and disclosures of PHI that are not permitted or required under applicable Law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable State Law.

Patient Rights

Patients are afforded various rights under HIPAA. Molina Providers must allow patients to exercise any of the below-listed rights that apply to the Provider's practice:

1. **Notice of Privacy Practices**
   Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the notice of privacy practices.

2. **Requests for Restrictions on Uses and Disclosures of PHI**
   Patients may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.

3. **Requests for Confidential Communications**

   Patients may request that a 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 (6) year period. The list of disclosures does not 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 Molina Member and patient PHI. As more Providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate cyber security measures. Providers should recognize that identity theft – both financial and medical -- is a rapidly growing problem and that their patients trust their health care Providers to keep their most sensitive information private and confidential.

Medical identity theft is an emerging threat in the 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 Molina.

HIPAA Transactions and Code Sets

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

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

Molina is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers should refer to Molina's website at MolinaHealthcare.com for additional information regarding HIPAA standard transactions. (Details are located under the HIPAA tab.)

Code Sets

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

National Provider Identifier (NPI)

Provider must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to Molina 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 Molina within thirty (30) days of the change. Providers must use their NPI to identify it on all electronic transactions required under HIPAA and on all Claims and Encounters submitted to Molina.

Additional Requirements for Delegated Providers

Providers that are delegated for Claims and Utilization Management activities are the "business associates" of Molina. Under HIPAA, Molina must obtain contractual assurances from all business associates that they will safeguard Member PHI. Delegated Providers must agree to various contractual provisions required under HIPAA's Privacy and Security Rules.

Reimbursement for Copies of PHI

Molina Healthcare does not reimburse Providers for copies of PHI related to our program Members. These requests may include, although are not limited to, the following purposes:

- Utilization Management
- Care Coordination and/or Complex Medical Care Management Services
- Claims Review
- Resolution of an Appeal and/or Grievance
- Anti-Fraud Program Review
- Quality of Care Issues
- Regulatory Audits
- Risk Adjustment
- Treatment, Payment and/or Operation Purposes;
- Collection of HEDIS® medical records.

MOLINA HEALTHCARE
Your Extended Family

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Member Name:			Member ID #:
Member Address:			Date of Birth:
City:	State:	Zip:	Phone #:

I authorize the use or disclosure of my protected health information (PHI) as stated below.

1. Name and address of Molina Healthcare (Molina) entity authorized to use or disclose the PHI:

2. Name and address of person or organization authorized to receive or use the PHI:

3. Description of the PHI that may be used and/or disclosed*:

*I know that this may include PHI related to:

- Sexually transmitted diseases;
- HIV/AIDS;
- Other communicable diseases;
- Behavioral or mental health diseases; and
- Referral and/or treatment for substance use disorder (as permitted under 42 CFR Part 2).

4. The PHI will be used and/or disclosed for the following purpose(s):

5. I know that:

   a. This authorization is voluntary.
   b. I do not have to sign this form. I can refuse to.
   c. My refusal to sign will not affect any of the following:

      - My eligibility for benefits or enrollment;
      - Payment for services; or
      - My ability to be treated.

d. I have a right to get a copy of this form. I must ask for a copy.
e. I may revoke this authorization at any time. To do so I have to let Molina know in writing. Such revocation will not apply to actions that Molina has taken in reliance on this authorization.
f. The PHI I authorize a person or entity to get may no longer be protected by federal law and regulations.

6. This authorization will expire on this date or event*: _____
**If not stated above, this authorization will expire 12 months from the date below.*

_____ _____

Signature of Member or Member's Personal Representative Date

_____ _____

Personal Representative's Name, if applicable (please print): _____

Relationship to Member: ☐Parent ☐Legal Guardian* ☐Holder of Power of Attorney *

☐Other Please Describe: _____

*** Please attach legal documentation if you are the legal guardian or Holder of Power of Attorney for Healthcare Decisions.**

A copy of this signed form will be given to the Member, if Molina sought it.

Contact Information

If you have any questions, please contact Molina Healthcare of Mississippi Member Services Department at the following:

Mail
Attn: Member Services
1020 Highland Colony Parkway Suite 602
Ridgeland, MS 39157

Phone
(844) 809-8438
TTY/TDD 711

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.

Section 11. Claims and Compensation

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

- Hospital Acquired Conditions and Present on Admission Program
- Claim Submission
- Coordination of Benefits (COB)/Third Party Liability (TPL)
- Timely Claim Filing
- Claim Edit Process
- Claim Review
- Claim Auditing
- Corrected Claims
- Timely Claim Processing
- Electronic Claim Payment
- Overpayment and Incorrect Payment
- Claims Disputes/Reconsiderations
- Billing the Member
- Fraud and Abuse
- Encounter Data

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 have been reasonably prevented by the use of evidenced-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. Effective October 1, 2008, CMS reduces payment for hospitalizations complicated by these categories of conditions that were not 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-Kenotic 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; and

No additional payment will be made on IPPS hospital Claims for conditions that are acquired during the patient's hospitalization.

Molina Coding Policies and Payment Policies

Frequently requested information on Molina'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.

Claim Submission

Participating Providers are required to submit Claims to Molina with appropriate documentation. Providers must follow the appropriate State and CMS Provider billing guidelines. Providers are strongly encouraged to utilize electronic billing though a clearinghouse or the Availity Essentials

portal whenever possible and 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 number: 77010.

Providers must bill Molina 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.

Written descriptions, itemized statements and invoices may be required for some types of Claims, or at the request of Molina. Claims for services that are reimbursed based on purchase price (e.g., custom DME or prosthetics) require the submission of the invoice with the Claim.

Required Elements

Electronic submitters should use the Implementation Guide and Molina Companion Guide for format and code set information when submitting or receiving files directly with Molina. In addition to the Implementation Guide and Companion Guide, electronic submitters should use the appropriate state specific Companion Guides and Provider Manuals. These documents are subject to change as new information is available. Please check the Molina website under EDI>Companion Guides for regularly updated information regarding Molina's companion guide requirements. Be sure to choose the appropriate State from the drop-down list on the top of the page. In addition to the Molina Companion Guide, it is also necessary to use the State Health Plan specific companion guides, which are also available on our Molina website for your convenience (remember to choose the appropriate state from the drop-down list).

Electronic Claim submissions will adhere to specifications for submitting medical Claims data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for Compliance SNIP levels 1 to 5.

The following information must be included on every Claim, whether electronic or paper:

- Member name, date of birth and Molina 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 National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Rendering Provider Information when different than billing
- Billing/Pay-to Provider name and billing address
- Place of service and type (for facilities)

- Disclosure of any other health benefit plans
- National Drug Code (NDC), unit of measure and quantity for medical injectables
- E-signature
- Service Facility Location information
- Any other state-required data

Provider and Member data will be verified for accuracy and active status. Be sure to validate this data in advance of Claims submission. This validation will apply to all Provider data submitted and also applies to atypical and out-of-state Providers.

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

National Provider Identifier (NPI)

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

Electronic Claims Submission

Molina strongly encourages participating Providers to submit Claims electronically, including secondary claims. Electronic Claims submission provides significant benefits to the Provider including:

- Helps to reduce operation costs associated with paper Claims (printing, postage, etc.)
- Increases accuracy of data and efficient information delivery
- Reduces Claim delays since errors can be corrected and resubmitted electronically
- Eliminates mailing time and Claims reach Molina faster

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina via the Availity Essentials portal
- Submit Claims to Molina via your regular EDI clearinghouse using Payer ID 77010

Availity Essentials Portal

The Availity Essentials portal is a no cost online platform that offers a number of Claims processing features:

- Submit Professional (CMS-1500) and Institutional (CMS-1450 [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.

Clearinghouse

Molina Healthcare of Mississippi uses ClaimsNet as its gateway clearinghouse. ClaimsNet has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit Claims to their usual clearinghouse.

If you do not have a clearinghouse, Molina offers additional electronic claims submissions options as shown by logging on to the Availity Essentials portal.

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

When your Claims are filed 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 refer to the Molina Companion Guide for information on the response format and messages.
- You should contact your local clearinghouse representative if you experience any problems with your transmission.

EDI (Clearinghouse) Submission

Corrected Claim information submitted via EDI submission are required to follow electronic Claim standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for Compliance SNIP levels 1 to 5. The 837 Claim format allows you to submit changes to Claims that were not included on the original adjudication

The 837 Implementation Guides refer to the National Uniform Billing Data Element Specifications Loop 2300 CLM05-3 for explanation and usage. In the 837 formats, the codes are called "Claim frequency codes." Using the appropriate code, you can indicate that the Claim is an adjustment of a previously submitted finalized Claim. Use the below frequency codes for Claims that were previously adjudicated.

Claim Frequency Code	Description	Action
7	Use to replace an entire Claim.	Molina will adjust the original Claim. The corrections submitted represent a complete replacement of the previously processed Claim.
8	Use to eliminate a previously submitted Claim.	Molina will void the original Claim from records based on request.

When submitting Claims noted with Claim frequency code 7 or 8, the original Claim number, must be submitted in Loop 2300 REF02 – Payer Claim Control Number with qualifier F8 in REF01. The original Claim number can be obtained from the 835 Electronic Remittance Advice (ERA). Without the original Claim number, adjustment requests will generate a compliance error and the Claim will reject.

Claim corrections submitted without the appropriate frequency code will deny as a duplicate and the original Claim number will not be adjusted.

EDI Claims Submission Issues

Providers who are experiencing EDI Submission issues should work with their clearinghouse to resolve this issue. If the Provider's clearinghouse is unable to resolve, the Provider should contact their Provider Services representative for additional support.

Paper Claim Submissions

Participating Providers should submit Claims electronically. If electronic claim submission is not possible, please submit paper claims to the following address:

Molina Healthcare of Mississippi
PO Box 22618
Long Beach, CA 90801

When submitting paper claims:

- Paper Claim submissions are not considered to be "accepted" until received at the appropriate Claims PO Box; Claims received outside of the designated PO Box will be returned for appropriate submission.
- Paper claims are required to be submitted on original red and white CMS-1500 and CMS-1450 (UB-04) claim forms.
- Paper Claims not submitted on the required forms will be rejected and returned. This includes black and white forms, copied forms, and any altering to include Claims with handwriting.
- Claims must be typed with either 10 or 12 point Times New Roman font, using black ink.
- Link to paper Claims submission guidance from CMS: cms.gov/Medicare/Billing/ElectronicBillingEDITrans/1500.

Corrected Claim Process

Providers may correct any necessary field of the CMS-1500 and CMS-150 (UB-04) forms.

Molina strongly encourages participating Providers to submit Corrected Claims electronically via EDI or the Availity Essentials portal.

All Corrected Claims:

- Must be free of handwritten or stamped verbiage (paper Claims).
- Must be submitted on a standard red and white CMS-1450 (UB-04) or CMS-1500 Claim form (paper Claims).

- Original Claim number must be inserted in field 64 of the CMS-1450 (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 CMS-1450 (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 CMS-1450 (UB-04) Claim forms.

Corrected Claims must be sent within 90 calendar days of Date of Service or most recent adjudicated date of the Claim.

Corrected Claims submission options:

- Submit Corrected Claims directly to Molina via the Availity Essentials portal.
- Submit corrected Claims to Molina via your regular EDI clearinghouse.

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

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured, or self-funded, or commercial carrier, automobile insurance, and worker's compensation) or program that is or may be liable to pay all or part of the health care expenses of the Member.

COB

CHIP is the payer of last resort. Private and governmental carriers must be billed prior to billing Molina or medical groups/IPAs. Provider shall make reasonable inquiry of Members to learn whether Member has health insurance, benefits or Covered Services other than from Molina or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Molina of said entitlement. In the event that COB 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 explanation of benefits (EOBs) and other required documents, by utilizing Molina's Provider Portal. Providers can also submit this information through EDI and Paper submissions.

TPL

Molina is the payer of last resort and will make every effort to determine the appropriate third-party payer for services rendered. Molina may deny Claims when a third party has been established and will process Claims for Covered Services when probable TPL has not been established or third-party benefits are not available to pay a Claim. Molina 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. CHIP members are only allowed to have vision and dental as other coverage.

Timely Claim Filing

Provider shall promptly submit to Molina Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina, and shall include all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by Provider to Molina within one-hundred eighty (180) calendar days after the discharge for inpatient services or the Date of Service for outpatient services. Claims filed within the appropriate time frame but denied can be corrected and submitted for reconsideration within ninety (90) days from the date of denial. If Molina is not the primary payer under coordination of benefits or third-party liability, Provider must submit Claims to Molina within one-hundred eighty (180) calendar days after final determination by the primary payer. Except as otherwise provided by Law or provided by Government Program requirements, any Claims that are not submitted to Molina within these timelines shall not be eligible for payment and Provider hereby waives any right to payment.

Reimbursement Guidance and Payment Guidelines

Providers are responsible for submission of accurate Claims. Molina requires coding of both diagnoses and procedures for all Claims as follows:.

- For diagnoses, the required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM.
- For procedures:
    - Professional and outpatient Claims require the Healthcare Common Procedure Coding System Level 1 (CPT codes), Level 2 and 3 (HCPCS codes)
    - Inpatient hospital Claims require ICD-10-PCS (International Classification of Diseases, 10th Revision, Procedure Coding System). Furthermore, Molina requires that all Claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

Molina 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 are not limited to, the following:

- Manuals and Relative Value Unit (RVU) files published by the Centers for Medicare and Medicaid Services (CMS), including:
    - National Correct Coding Initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and Medically Unlikely Edits (MUEs). In the event a State benefit limit is more stringent/restrictive than a Federal MUE, Molina 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 (NCDs).
    - In the absence of State guidance, Medicare Local Coverage Determinations (LCDs).
    - 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.
- Molina policies based on the appropriateness of health care and Medical Necessity.
- Payment policies published by Molina.

General Coding Requirements

Correct coding is required to properly process claims. Molina 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 (2) 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 code books.

ICD-10-CM/PCS codes

Molina 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 do not meet Molina'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.

Place of Service (POS) Codes

Place of Service 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's) 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.

Molina processes DRG claims through DRG software. If the submitted DRG and system-assigned DRG differ, the Molina-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 cannot be grouped due to insufficient information, it will be denied and returned for lack of sufficient information.

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 are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. There are 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 are 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

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

Provider acknowledges Molina's right to conduct pre and post-payment billing audits. Provider shall cooperate with Molina's Special Investigations Unit 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 Molina'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, Molina may select a statistically valid random sample, or smaller subset of the statistically valid random sample. This sample gives an estimate of the proportion of claims Molina 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. Molina asks that you provide us, or our designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

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

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

Corrected Claims

Corrected Claims are considered new Claims for processing purposes. Corrected Claims may be submitted electronically with the appropriate fields on the 837I or 837P completed. Molina's Provider Portal includes functionality to submit corrected Institutional and Professional Claims. Corrected Claims must include the correct coding to denote if the Claim is Replacement of Prior Claim or Corrected Claim for an 837I or the correct Resubmission Code for an 837P and include the original claim number.

Claims submitted without the correct coding will be returned to the Provider for resubmission.

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 Molina or contracted medical group/IPA have agreed in writing to an alternate schedule, Molina will process the Claim for service within thirty (30) calendar days after receipt of Clean Claims.

The receipt date of a Claim is the date Molina receives notice of the Claim.

Electronic Claim Payment

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

Overpayments and Incorrect Payments Refund Requests

- If, as a result of retroactive review of Claim payment, Molina 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:
- Submit a refund to satisfy overpayment,
- Submit request to offset from future claim payments, or
- 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 Molina standards 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, Molina will provide notice within 270 days from the

claim's paid date if the primary insurer is a Commercial plan. 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. Molina 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 Molina 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 Molina 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 Molina, or the date that the Provider receives a payment from Molina that reduces or deducts the overpayment.

Claim Disputes/Reconsiderations

Providers disputing a Claim previously adjudicated must request such action within 30 days of Molina's original remittance advice date. Regardless of type of denial/dispute (service denied, incorrect payment, administrative, etc.); all Claim disputes must be submitted on the Molina Claims Request for Reconsideration Form (CRRF) found on Provider website and the Provider Portal. The form must be filled out completely in order to be processed.

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

- 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, mail, or provider portal. Claims Disputes/Reconsideration requested via the CRRF may be sent to the following address:

Molina Healthcare of Mississippi, Inc.
Attention: Claims Disputes/Adjustments
1020 Highland Colony Parkway Suite 602
Ridgeland, MS 39157

Submitted via fax: (844) 808-2409

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.

The Provider will be notified of Molina's decision in writing within 30 days of receipt of the Claims Dispute/Adjustment request.

Billing the Member

- Providers contracted with Molina cannot bill the Member for any covered benefits beyond applicable copayment. 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 owed by Molina to the Provider
- Provider agrees to accept payment from Molina as payment in full, or bill the appropriate responsible party
- Provider may not bill a Molina Member for any unpaid portion of the bill or for a Claim that is not paid with the following exceptions:
    - The Member has been advised by the Provider that the service is not a covered benefit and the Provider has documentation.
    - The Member has been advised by the Provider that he/she is not contracted with Molina and has documentation.
    - The Member agrees in writing to have the service provided with full knowledge that they are financially responsible for payment.

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 Molina 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.

Encounter data must be submitted at least once per month, and within thirty (30) days from the 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.

Molina has a comprehensive automated and integrated Encounter data system capable supporting all 837 file formats and proprietary formats if needed.

Molina has created 837P, 837I, and 837D Companion Guides with the specific submission requirements available to Providers.

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

When Encounters are filed electronically Providers should receive two (2) types of responses:

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

Section 12. Complaints, Grievance and Appeals Process

Member Complaints, Grievance and Appeals Process

Members may identify in writing an individual, including an attorney or Provider, to serve as a personal representative to act on their behalf at any stage during the grievance and appeals processes. If under applicable Law, a person has authority to act on behalf of a Member in making decisions related to health care or is a legal representative of the Member, Molina will treat such person as a personal representative.

Members are notified of their grievance and appeal rights and the different levels of grievances and appeals through various general communications including, but not limited to, the Member handbook, Member newsletters and Molina's website: MolinaHealthcare.com. Members are notified of these rights upon enrollment, and annually thereafter.

If a Member is unhappy with the service from Molina or Providers contracted with Molina, they may file a complaint, grievance or appeal by contacting Member Services toll-free at (844) 809-8438, Monday through Friday 7:30 a.m. to 8 p.m., and Saturday and Sunday of the second weekend of every month from 8 a.m. to 5 p.m. They can also write to us at:

Molina Healthcare of Mississippi
Attention: Grievance & Appeals Department
1020 Highland Colony Parkway Suite 602
Ridgeland, MS 39157

Members may also send their written request via fax to: (844) 808-2407

This section addresses the identification, review and resolution of Member grievances and appeals. Below are Molina's Member Grievance and Appeals Process.

Member Complaint and Grievance Process

Molina ensures that Members have access to the complaint and grievance process by aiding in a culturally and linguistically appropriate manner. Members are provided toll free telephone numbers as well as telephone numbers that access TTY/TDD services. Assistance is available for oral, written, and language interpretation. Alternative formats and devices that assist disabled individuals with communication are available if needed. The Mississippi Division of Medicaid Office of the Governor ("Division") has the right to intercede on the Member's behalf at any time during the Complaint and Grievance process whenever there is an indication from the Member that a serious quality of care issue is not being addressed timely or appropriately. Additionally, the Member may be accompanied by a representative of their choice to any proceedings.

A Member may file a Complaint or a Grievance orally or in writing. Complaints may be submitted within (30) calendar days of the date of the event causing the dissatisfaction. Grievances may be filed at any time after the date of event causing dissatisfaction.

A Complaint is an expression of dissatisfaction, regardless of whether identified by the Member as a "Complaint", received by any employee of Molina that is of a less serious or formal nature that is resolved within one calendar day of receipt. If the complaint cannot be resolved, it will be treated as a formal grievance.

A Grievance is an expression of dissatisfaction, regardless of whether identified by the Member as a "Grievance" received by Molina about any matter or aspect of Molina or its operation, other than a Molina's Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights regardless of whether remedial action is requested. Grievance includes a Member's right to dispute an extension of time proposed by Molina.

A written acknowledgement letter must be sent within five (5) calendar days of receipt of a Grievance. Grievances must be resolved as expeditiously as possible, but no later than (30) calendar days from receipt.

A Member Resolution Team (MRT) Specialist will be assigned the case and will be responsible for resolving and providing a resolution letter to the Member. During the course of researching a Grievance, it is expected that the MRT Specialists, when appropriate, partner with other Molina Departments (e.g. Provider Services, Health Care Services, Quality, etc.) and/or reach out to a Provider or facility as needed. The MRT Specialist will investigate the grievance and secure any additional pertinent records (billing notices, Pharmacy Claims etc.) for all Grievances.

The timeframe for Grievance resolution may be extended by up to fourteen (14) calendar days if the following occur:

- The Member requests the extension, or
- Molina determines an extension is in the interest of the Member and Molina advises the Member verbally and in writing of the reason for the extension within two calendar days from the date of the decision to extend the time frame.

Any grievances related to a clinical denial and/or appeal of a coverage decision, undergoes clinical review by a person not involved in the previous decision-making process to determine Medical Necessity aspects of the request.

Any grievance with Potential Quality of Care (PQOC) and/or Critical Incidents issues is referred to the Quality Department for further investigation and handling. Additionally, any identified issue related to the Privacy and Confidentiality of Protected Health Information (PHI) is referred to the Privacy Officer.

Member Appeals Process

Appeals may be filed orally or in writing. If the appeal request is made orally, Molina must get a signed, written appeal request within 30 calendar days after getting the verbal appeal request, unless an expedited (fast) plan appeal is requested. An appeal is a request for Molina to review an Adverse Benefit Determination. An Adverse Benefit Determination for a Member may include a decision to deny or limit health care services a Member believes he or she is entitled to get. In the case of a Member, the Adverse Benefit Determination may include determinations on the health care services a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Member).

Molina ensures that Members have access to the Appeal process by aiding throughout its

entirety in a culturally and linguistically appropriate manner. Members are also provided with toll-free telephone numbers, telephone numbers that have adequate TTY/TDD, assistance with oral, written, and language interpretation, sign language assistance, and alternate formats and devices that aid disabled individuals to communicate if needed.

Members have the opportunity to present evidence and allegations of fact or Law, in person as well as in writing. The Member (and/or Member's representative) and regulatory or oversight agencies are permitted to have reasonable access to examine and obtain copies of appeal files, including medical records and any other documents before, during, and after the Appeal process at no charge to the Member.

Appeals may be filed within (60) calendar days from the Adverse Benefit Determination notice. A written acknowledgement letter must be sent within ten (10) calendar days of receipt of the Appeal. Appeal must be resolved as expeditiously as possible as; no later than (30) calendar days from receipt.

The timeframe for Appeals resolution may be extended by up to fourteen (14) calendar days if the Member requests the extension. Molina may extend the timeframe (14) calendar days if the extension is in the interest of the Member and Molina advises the Member verbally and in writing of the reason for the extension within two calendar days from the date of the decision to extend the time frame.

A person not involved in the previous decision-making process reviews the appeal to determine the resolution. Appeals involving the denial of clinical services, health care professionals with appropriate expertise conduct the review. A Medical Director of same or similar specialty who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination will review the appeal and make the determination.

For decisions not resolved wholly in the Member's favor, the written response to the Appeal will include the following information:

- The right to request an Independent External Review;
- How to request an Independent External Review, and if applicable;
- The right to continue to receive benefits pending an Independent External Review;
- How to request the continuation of benefits;
- Information that the Member may be liable for the cost of any continued benefits if the Plan's action is upheld at the Independent External Review; and
- The Member's right, upon request, to have access to and copies of all documents relevant to the Member's Appeal.

Expedited Review Process

An appeal will be expedited in response to the clinical urgency of the situation; i.e., when it is determined that allowing the time for a standard resolution could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function. A request to expedite may come from the Member, a Provider, or when Molina feels it prudent to do so. An expedited appeal will be acted on quickly and a decision made within (72) hours.

The timeframe for Expedited Appeals resolution may be extended by up to (14) calendar days if the Member requests the extension. Molina may request an additional (14) calendar days if the extension is in the interest of the Member and Molina advises the Member verbally and in writing within two calendar days of the decision to extend the time frame.

Molina does not require an oral Expedited Appeal request to be followed by a written, signed appeal. However, if a written request is received, the date of the oral filing will be considered the filing date of the Appeal. Molina considers the Member, Member Representative, or estate representative of a deceased Member, as parties to the Appeal.

If an expedited Appeal request does not meet the expedited criteria, it will be processed as a standard Appeal. The requestor is notified within (24) hours and a determination is made within (30) calendar days.

Review by Independent External Review

Members may request an Independent External Review through the Subcontractor MLS Group of Companies for any Appeal that is not resolved wholly in the Member's favor. However, Molina's appeals process must first be exhausted. Molina will inform and assist the Member with filing an Independent External Review request if the final decision by Molina is not wholly in the Member's favor. An explanation of Molina's Appeals process and the Independent External Review request process is also found in the Member Handbook, and on the Molina website at MolinaHealthcare.com.

A Member who has completed the Managed Care Plan's appeal process may file for an Independent External Review within (120) calendar days of receipt of the notice of plan appeal resolution.

To ask for an Independent External Review, you may submit your request to the Molina Appeals and Grievance department. The Appeals and Grievance team will submit the Independent External Review to the MLS Group of Companies for review; the MLS Group of Companies will contact you when the review is completed. Please submit your request to the following:

Independent External Review Request
Attn: Member Grievance & Appeals
1020 Highland Colony Parkway Suite 602
Ridgeland, MS 39157
Fax Number: (844) 808-2407

Molina will continue services for the member during the plan appeal or, if requested, an Independent External Review, if a plan appeal has been requested AND all of the following guidelines have been met:

1. Member asks for continuation of benefits on or before ten calendar days from Molina sending the notice of appeal resolution, or on or before the date when changes to benefits start, whichever date is later;
2. The Appeal involves services that Molina had already authorized;
3. The services were ordered by an authorized service Provider;

4. The time period covered by the original authorization has not expired; and
5. Member requests an extension of the benefits.

Molina will provide benefits until one of the following occurs:

1. Member withdraws the Appeal;
2. Ten calendar days pass after Molina sends the member a letter with the appeal decision, if the Appeal was denied and member has not requested an Independent External Review or taken any further action;
3. The MLS Group of Companies issues an Independent External Review decision not in the member's favor; and
4. The time period or service limits of a previously authorized service has expired.
5. Should an Independent External Review result in the reversal of an Adverse Benefit Determination, Molina shall bear all costs associated with the review. These costs may include, but are not limited to: medical appropriateness reviews by the MLS Group of Companies, contracted Independent Physician Reviewers, review officer's fees, attorney's fees, and court reporter's fees

Reporting

Grievance and appeal trends are reported to the Quality Improvement Committee quarterly. This trend report includes a quantitative review of trends, qualitative or barriers analysis, and identification of interventions that address key drivers. An annual evaluation of grievance and appeal analysis is then completed and presented to the Quality Improvement Committee for evaluation. If required by the state or CMS, reporting is submitted to the Appropriate Agency as needed.

Provider Complaints, Grievance and Appeals Processes

Providers have the right to file a complaint, grievance or appeal through a formal process. The Division shall have the right to intercede on a Provider's behalf at any time during the Contractor's Complaint, Grievance, and/or Appeal process whenever there is an indication from the Provider, or, where applicable, authorized person, that a serious quality of care issue is not being addressed timely or appropriately.

Provider Complaint and Grievance Process

Providers may file a complaint within (30) calendar days of the date of the event causing the dissatisfaction. A Complaint is an expression of dissatisfaction, regardless of whether identified by the Provider as a "Complaint", received by Molina orally or in writing that is of a less serious or formal nature that is resolved within one business day of receipt. A Complaint includes, but is not limited to inquiries, matters, misunderstandings, or misinformation that can be promptly resolved by clearing up the misunderstanding, or providing accurate information. Any Complaint not resolved within one calendar day shall be treated as a Grievance.

A Provider may file a complaint or formal grievance by contacting the Molina toll-free at (844) 826-4335, Monday through Friday 7:30 a.m. to 5:30 p.m. excluding State holidays.

Providers may also send their written grievance via fax to: (844) 808-2409

A Provider may file a grievance orally or in writing. An expression of dissatisfaction, regardless of whether identified by the Provider as a "Grievance", received by Molina about any matter or aspect of Molina or its operation, other than a Molina's Adverse Benefit Determination.

Grievances may be filed within (30) calendar days from the date of event causing dissatisfaction. A written acknowledgement letter must be sent within five calendar days of receipt of a Grievance. Grievances must be resolved as expeditiously as possible as but no later than (30) calendar days from receipt.

The timeframe for Grievance resolution may be extended up to (14) calendar days and in compliance with State regulation.

Provider Appeals Process

A Provider may file a formal Appeal orally or in writing. An appeal is a request for Molina to review an Adverse Benefit Determination related to a Provider; which may include, but is not limited to, for cause termination by the Molina, or delay or non-payment for Covered Services.

Appeals must be filed within (30) calendar days from the Adverse Benefit Determination or denial. A written acknowledgement letter must be sent within ten calendar days of receipt of the Appeal. Appeal must be resolved as expeditiously as possible, and no later than thirty (30) calendar days from receipt.

The timeframe for Appeals resolution may be extended up to (14) calendar days in compliance with State regulation.

For decisions not resolved wholly in the Provider's favor, Providers have the right to request an Independent External Review from the MLS Group of Companies.

Appeals related to Claims must be submitted on the Molina Claims Request for Reconsideration Form (CRRF) found on Provider website and the Provider Portal. The form must be filled out completely in order to be processed. Appeals about determinations other than Claim payment do not require the CRRF and should be faxed to Molina.

Providers must submit the following documentation:

- Any documentation to support the adjustment and a copy of the Authorization form (if applicable) must accompany the Claim dispute/reconsideration request.
- The Claim number clearly marked on all supporting documents

Forms may be submitted via fax or Provider Portal.

Submitted via fax: (844) 808-2409

Submitted via Provider Portal: provider.MolinaHealthcare.com.

Expedited Review Process

Providers may request that an appeal be expedited in compliance with State regulations. An expedited appeal will be acted on quickly and a decision made within three calendar days. Molina may extend the time frame by up to (14) calendar days if the Member requests the extension. Molina may request an additional (14) calendar days if the extension is in the interest of the Member and Molina advises the Member in writing within two calendar days of the decision to extend the time frame.

Molina will review the request to ensure it meets the requirements for expedited review. If the case does not meet expedited review, the requestor is notified, and the case is processed as a standard appeal.

Review by Independent External Review

Providers may request an Independent External Review through the MLS Group of Companies for any Appeal that is not resolved wholly in the Provider's favor.

Once a Provider has exhausted Molina's appeal process, they may file an Independent External Review within (30) calendar days of the final decision by Molina.

To ask for an Independent External Review, you may submit your request to the Molina Appeals and Grievance department. The Appeals and Grievance team will submit the Independent External Review to the MLS Group of Companies for review; the MLS Group of Companies will contact you when the review is completed. Please submit your request to the following:

Independent External Review Request
Attn: Member Grievance & Appeals
1020 Highland Colony Parkway Suite 602
Ridgeland, MS 39157
Fax Number: (844) 808-2407

Should an Independent External Review result in the reversal of an Adverse Benefit Determination, Molina shall bear all costs associated with the review. These costs may include, but are not limited to; medical appropriateness reviews by the contracted Independent Physician Reviewers, review officer's fees, attorney's fees, and court reporter's fees.

Record Retention

Molina will maintain all grievance and related appeal documentation on file for a minimum of ten years. In addition to the information documented electronically in Molina's core processing system or maintained in other electronic files, Molina Healthcare will retain copies of any written documentation submitted by the Provider pertaining to the grievance/appeal process.

Section 13. Credentialing and Recredentialing

Centralized Credentialing

Effective July 1, 2022, the MS Department of Medicaid (DOM) centralized credentialing processes for the Medicaid line of business. That means that once a Medicaid ID number has been issued, a provider only needs to pursue a contract with Molina for Medicaid purposes. Molina will no longer credential a provider for MSCAN or CHIP purposes. DOM has sub-contracted with a company, Gainwell Technology, for credentialing processes so please respond to any credentialing requests coming from Gainwell. Delayed responses to Gainwell will delay the credentialing process, and as a result delay the Molina contracting process.

Centralized credentialing **does not apply** to the Marketplace line of business. If you are contracted with Molina for any other lines of business, including Marketplace, you are still required to participate in Molina Credentialing processes. Please continue to respond to credentialing requests from Molina to ensure your network status for Marketplace lines of business remains current.

Type of Practitioners Credentialed & Recredentialed

Practitioner types requiring credentialing include but are not limited to:

- Acupuncturists
- Addiction medicine specialists
- Audiologists
- Behavioral healthcare practitioners who are licensed, certified or registered by the State to practice independently
- Chiropractors
- Clinical Social Workers
- Dentists
- Doctoral or master's -level psychologists
- Licensed/Certified Midwives (Non-Nurse)
- Massage Therapists
- Master's-level clinical social workers
- Master's-level clinical nurse specialists or psychiatric nurse practitioners
- 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

Recredentialing

The Mississippi Division of Medicaid is responsible for credentialing/recredentialing all providers that participate in the Managed Care programs (Mississippi Coordinated Access Network, MSCAN) and (Mississippi Children's Health Insurance Program, MSCHIP).

Recredentialing is required every three years. Information on file should be reviewed for accuracy. A provider must be enrolled in MSCAN and/or MSCHIP to recredential. Providers will receive a letter 180 days prior to their recredential due date and their recredentialing link will be available on the Home Page of the MESA Provider Portal. You will have 60 days to submit your recredentialing application. The process incorporates a reverification and identification of changes to a provider's licensure, sanctions and certifications to ensure you still meet the National Committee on Quality Assurance (NCQA) standards.

There is a list of providers that are due for recredentialing on the Division Of Mississippi Medicaid website. See link under Providers>Provider Six-Month License Due List: Home - Mississippi Division of Medicaid (ms.gov). Providers that fail to recredential or submit supporting documentation by the deadline will be terminated and will no longer be able to participate in a Coordinated Care Organization (CCO) network. Ordering Referring Prescribing (ORP) providers are not able to enroll in Managed Care Programs therefore do not require credentialing.

Section 14. Risk Adjustment Management Program

What is Risk Adjustment?

Risk Adjustment is 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 Molina members and prepares for resources that may be needed in the future.

Why is Risk Adjustment Important?

- Allows Molina to focus on quality and efficiency.
- Enables Molina to recognize and address current and potential health conditions early.
- Identifies members for Care Management referral.
- Ensures accurate payment for the acuity levels of Molina members.
- Risk Adjustment allows Molina to have the resources to deliver the highest quality of care to Molina members.

Your Role as a Provider

As a Provider your documentation in a member's medical record is critical to a Member's quality of care .

For a complete and accurate medical record, all Provider documentation must:

- Be compliant with CMS correct coding initiative.
- Use the correct ICD-10 code by coding the condition to the highest level of specificity.
- Only submit codes for diagnoses confirmed during a face to face visit with the Member.
- Contain a treatment plan.
- Be clear and concise.
- Contain the Member's name and date of service.
- Have the physician's signature and credentials.

Interoperability

Provider agrees to deliver relevant clinical documents (Clinical Document Architecture (CDA) or Continuity of Care Document (CCD) format) at encounter close for Molina Members by using one of the automated methods available and supported by Provider's electronic medical records (EMR), including, but not limited to, Direct protocol, Secure File Transfer Protocol (sFTP), query or Web service interfaces such as Simple Object Access Protocol (External Data Representation) or Representational State Transfer (Fast Healthcare Interoperability Resource). CCDA or CCD document should include signed clinical note or conform with the United States Core Data for Interoperability (USCDI) common data set and Health Level 7 (HL7) CCDA standard.

Provider will also enable HL7 v2 Admission/Discharge/Transfer (ADT) feed for all patient events for Molina Members to the interoperability vendor designated by Molina.

Provider will participate in Molina's program to communicate Clinical Information using the Direct Protocol. Direct Protocol is the Health Insurance Portability and Accountability Act (HIPAA) compliant mechanism for exchanging healthcare information that is approved by the Office of the National Coordinator for Health Information Technology (ONC).

If the Provider does not have Direct Address, Provider will work with its EMR vendor to set up a Direct Account, which also supports the Centers for Medicare & Medicare Services (CMS) Requirement of having Provider's Digital Contact Information added in the National Plan and Provider Enumeration System (NPPES).

If Provider's EMR does not support the Direct Protocol, Provider will work with Molina's established interoperability partner to get an account established.

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 Molina is accurate. All claims/encounters submitted to Molina are subject to State and/or Federal and internal health plan auditing. If Molina is selected for a RADV audit, providers will be required to provide medical records to validate the previously submitted data.

Contact Information

For questions about Molina's Risk Adjustment programs, please contact your Molina Provider Services representative.

Section 15. Single Pharmacy Benefit Administrator (SPBA) Program

Single Pharmacy Benefit Administrator (SPBA) Program Overview

Effective July 1, 2024, Mississippi Medicaid will implement a new pharmacy services model by introducing a Single Pharmacy Benefit Administrator (SPBA) to serve all coordinated care organizations within the state.

The selected SPBA, Gainwell Technologies, will assume comprehensive responsibilities encompassing claims management and payment, prior authorization, and overseeing the pharmacy network for all members. Learn more about the SPBA and access the secure provider portal here at portal.ms-medicaid-mesa.com/ms/provider/Resources/SearchProviders/tabid/220/Default.aspx.

All Medicaid managed care members are automatically enrolled with the SPBA. Additionally, Gainwell Technologies is required to contract with all enrolled pharmacy providers who are willing to accept the SPBA contract terms, resulting in a broad pharmacy network that will ensure access for all members statewide.

Any Covered Outpatient Drug billed on an outpatient medical claim, as opposed to a pharmacy claim, will continue to fall under the responsibility of Molina Healthcare of Mississippi.

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