



## PROVIDER MANUAL

Molina Healthcare of Nevada, Inc.

(Molina Healthcare or Molina)

**Medicaid**  
**Nevada Check Up**

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](https://www.MolinaHealthcare.com).

Last Updated: 07/2022

## **Molina Healthcare of Nevada, Inc. Provider Manual Addendum – July 2022**

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**Required Update:** New language will be added

**Section Title:** Risk Adjustment Management Program

**Subsection Title:** Interoperability

**The following new language will be added:**

### **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 health care information that is approved by the Office of the National Coordinator for Health Information Technology (ONC).

- If 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.

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# 1. CONTACT INFORMATION

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Molina Healthcare of Nevada, Inc.  
8329 W Sunset Road., Suite 100  
Las Vegas, NV 89113

## Provider Services Department

The Provider Services department handles telephone and written inquiries from Providers regarding address and Tax-ID changes, contracting and training. The department has Provider Services representatives who serve all of Molina's Provider network. Eligibility verifications can be conducted at your convenience via the Availity Essentials [Provider Portal](#). The Provider Services department is available by phone Monday through Friday 8 a.m. to 6 p.m. excluding New Year's Day, Martin Luther King Jr. Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day.

Phone: (833) 685-2103

Fax: (833) 741-3182

## 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 8 a.m. to 6 p.m., Monday through Friday, excluding New Year's Day, Martin Luther King Jr. Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day. Eligibility verifications can be conducted at your convenience via the Provider Portal.

Phone (833) 685-2102

TTY/TDD: 711

## Claims Department

Molina strongly encourages Participating Providers to submit Claims electronically (via a clearinghouse or Availity Provider Portal) whenever possible.

- Access the Availity [Provider Portal](#)
- EDI Payer ID: MLNNV

If electronic Claim submission is not possible, please submit paper Claims to the following address:

Molina Healthcare of Nevada, Inc.  
PO Box 22666  
Long Beach, CA 90801

To verify the status of your Claims, please use the Availity [Provider Portal](#). For other Claims questions contact Provider Services.

## Claims Recovery Department

The Claims Recovery department manages recovery for overpayment and incorrect payment of Claims.

Phone: (866) 642-8999

## Compliance and Fraud Alert Line

If you suspect cases of fraud, waste, or abuse, you must report it to Molina. You may do so by contacting the Molina Alert Line 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 Provider Manual.

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

Phone: (866) 606-3889

Website: [MolinaHealthcare.alertline.com](http://MolinaHealthcare.alertline.com)

## Credentialing Department

The Credentialing department verifies all information on the Provider Application prior to contracting and re-verifies this information every three years, or sooner depending on Molina's credentialing criteria. The information is then presented to the Professional Review Committee to evaluate a Provider's qualifications to participate in the Molina network.

Molina Healthcare of Nevada, Inc.  
8329 W Sunset Road., Suite 100  
Las Vegas, NV 89113

Phone (833) 685-2103

## 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 24 hours a day, seven days a week to assess symptoms and help make good health care decisions.

Phone: (833) 685-2104

TTY/TDD: 711 Relay

## Healthcare Services Department

The Healthcare Services (formerly Utilization Management) department conducts concurrent review on inpatient cases and processes Prior Authorizations/Service Requests. The Healthcare Services (HCS) department also performs Care Management for Members who will benefit from Care Management services. Participating Providers are required 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 Availity Provider Portal.
- Submit requests via 278 transactions.

See the EDI tab of Molina's Provider website for guidance.

- Provider Portal: [Provider.MolinaHealthcare.com](http://Provider.MolinaHealthcare.com)
- Phone: (833) 685-2103
- PA Fax: (775) 460-4900

## Health Management

Molina's Health Management programs will be incorporated into the Member's treatment plan to address the Member's health care needs.

Molina Healthcare of Nevada, Inc. Medicaid and Nevada Check Up Provider Manual.  
Any reference to Molina Members means Molina Healthcare Medicaid/Nevada Check Up Members.

Phone: (833) 685-2103

Email: [CareManagement\\_Molina\\_Nevada@MolinaHealthcare.com](mailto:CareManagement_Molina_Nevada@MolinaHealthcare.com)

## **Behavioral Health**

Molina manages all components of Covered Services for behavioral health. For Member behavioral health needs, please contact us at (833) 685-2103. For after-hours Behavioral Health Case Management needs, Members may contact (833) 685-2102,

24 hours per day, 365 days per year.

## **Pharmacy Department**

Prescription drugs are covered through CVS. A list of in-network pharmacies are available on the [MolinaHealthcare.com](http://MolinaHealthcare.com) website or by contacting Molina:

Phone: (833) 685-2103

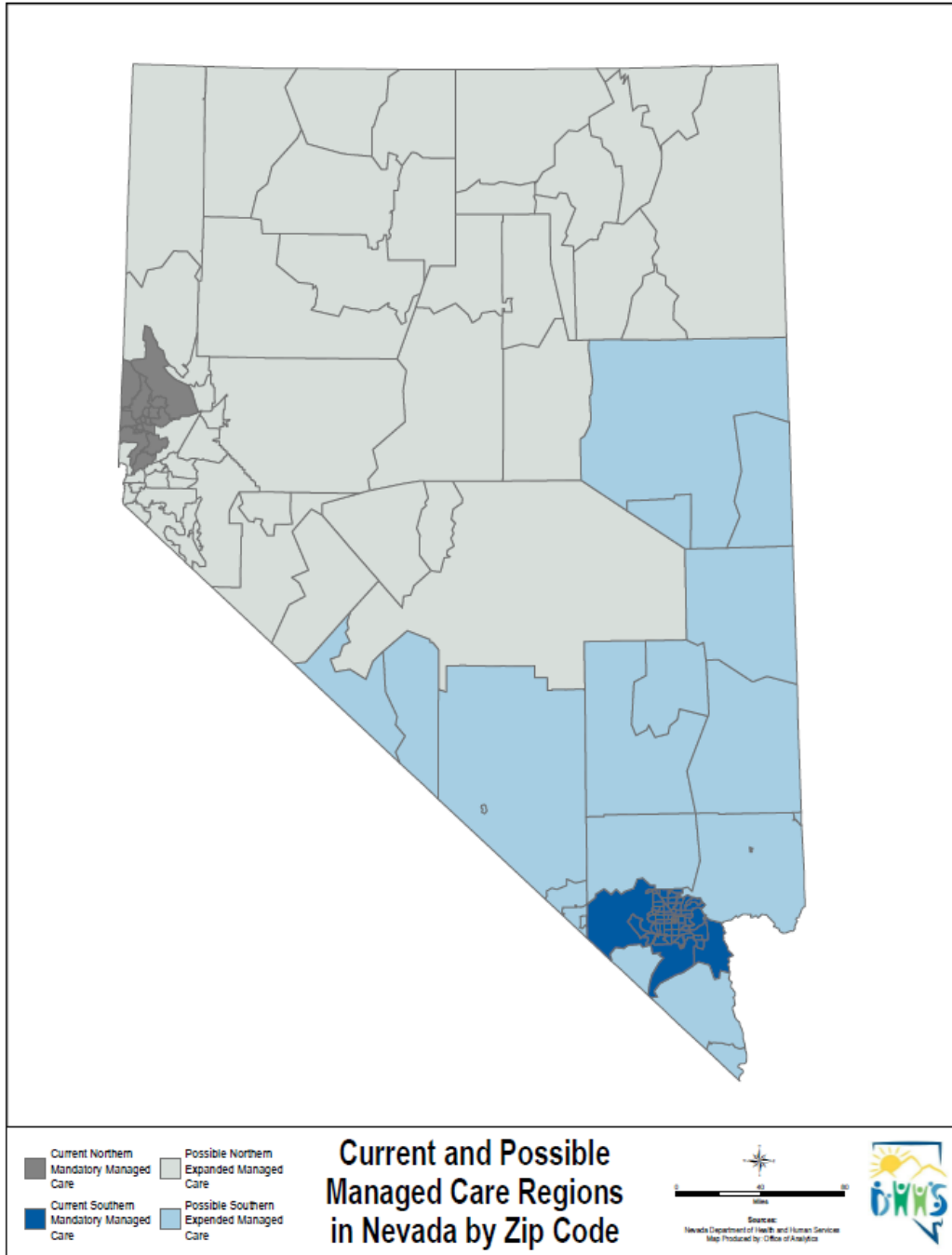
Pharmacy PA Fax: (844) 259-1689

## **Quality Improvement**

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

Phone: (833) 685-2103

## Molina Healthcare of Nevada, Inc. Service Area





## 2. PROVIDER RESPONSIBILITIES

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### Non-discrimination of Health Care Service Delivery

Molina complies with the guidance set forth in the final rule for Section 1557 of the Affordable Care Act (ACA), which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina website home pages. All Providers who join the Molina Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR).

For more information about Non-discrimination of Health Care Service Delivery, please see the Cultural Competency and Linguistic Services section of this Provider Manual.

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

Toll Free: (866) 606-3889

TTY/TDD: 711

Online: [MolinaHealthcare.AlertLine.com](https://MolinaHealthcare.AlertLine.com)

Email: [civil.rights@MolinaHealthcare.com](mailto:civil.rights@MolinaHealthcare.com)

Should you or a Molina Member need more information, you can refer to the Health and Human Services website: [federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority](https://www.federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority).

### Facilities, Equipment and Personnel

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

## 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 Members and Provider Network.

Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirement, as well as an NCQA required element. Invalid information can negatively impact Member access to care, Member/PCP assignments and referrals. Additionally, current information is critical for timely and accurate Claims processing.

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

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

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

Please visit our Provider Online Directory at [MolinaHealthcare.com](https://molinahealthcare.com) to validate your information. A convenient Provider web form can be found on the website at:

[MolinaHealthcare.com/providers/nv/medicaid/resources/forms.aspx](https://molinahealthcare-my.sharepoint.com/personal/cynthia_delatorre_molinahealthcare_com/Documents/Desktop/Projects in Progress/MolinaHealthcare.com/providers/nv/medicaid/resources/forms.aspx)  
[https://molinahealthcare-my.sharepoint.com/personal/cynthia\\_delatorre\\_molinahealthcare\\_com/Documents/Desktop/Projects in Progress/MolinaHealthcare.com/providers/nv/medicaid/resources/forms.aspx](https://molinahealthcare-my.sharepoint.com/personal/cynthia_delatorre_molinahealthcare_com/Documents/Desktop/Projects in Progress/MolinaHealthcare.com/providers/nv/medicaid/resources/forms.aspx) if your information needs to be updated or corrected.

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

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 the Provider Directory or otherwise impacts its membership or ability to coordinate Member care. Providers are required to supply timely responses to such communications.

## National Plan and Provider Enumeration System (NPPES) Data Verification

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

NPPES allows Providers to attest to the accuracy of their data. If the data is correct, the Provider is able to attest and NPPES will reflect the attestation date. If the information is not correct, the Provider is able to request a change to the record and attest to the changed data, resulting in an updated certification date.

Molina supports the CMS recommendations around NPPES data verification and encourages our Provider network to verify Provider data via [nppes.cms.hhs.gov](https://nppes.cms.hhs.gov). Additional information regarding the use of NPPES is available in the Frequently Asked Questions (FAQs) document published at the following link: [cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index](https://cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index).

## Molina Electronic Solutions Requirements

Molina requires Providers to utilize electronic solutions and tools whenever possible.

Molina requires 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 inquiries, health plan access to electronic medical records (EMR), electronic claims submission, electronic fund transfers (EFT), electronic remittance advice (ERA), electronic Claims Appeal and registration for and use of the Availity [Provider Portal](#) (Provider Portal).

Electronic Claims include claims submitted via a clearinghouse using the EDI process and claims submitted through the Provider Portal.

Any Provider entering the network as a Contracted Provider will be encouraged to comply with Molina's Electronic Solution Policy by enrolling for EFT/ERA payments, registering for the Availity Provider Portal within 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 HIPAA Transactions, including Claims submitted to Molina. Providers may obtain additional information by visiting Molina's HIPAA Resource Center [MolinaHealthcare.com/providers/nv/medicaid/resources/hipaa.aspx](https://MolinaHealthcare.com/providers/nv/medicaid/resources/hipaa.aspx) located on our website at [MolinaHealthcare.com](https://MolinaHealthcare.com).

## Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Molina Providers include:

Molina Healthcare of Nevada, Inc. Medicaid and Nevada Check Up Provider Manual.  
Any reference to Molina Members means Molina Healthcare Medicaid/Nevada Check Up Members.

- Electronic Claims Submission Options
- Electronic Payment: EFT with ERA
- [Provider 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 such as:

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

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina via the Availity [Provider Portal](#).
- Submit Claims to Molina through your EDI clearinghouse using Payer ID MLNNV, refer to our website [MolinaHealthcare.com](http://MolinaHealthcare.com) for additional information.

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

Provider Portal Claims submission includes the ability to:

- Add attachments to Claims.
- Submit corrected Claims.
- Easily and quickly void Claims.
- Check Claims status.
- Receive timely notification of a change in status for a particular Claim.
- Ability to Save incomplete/un-submitted Claims.
- Create/Manage Claim templates.

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

## Electronic Payment (EFT/ERA) Requirement

Participating Providers are required 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: [MolinaHealthcare.com](http://MolinaHealthcare.com).

## Availity Provider Portal

Providers and third-party billers can use the no cost Availity [Provider Portal](#) to perform many functions online without the need to call or fax Molina. Registration can be performed online and once completed the easy-to-use tool offers the following features:

- Verify Member eligibility, covered services and view HEDIS needed services (gaps)
- Claims:
  - Submit Professional (CMS1500) and Institutional (UB04) Claims with attached files
  - Correct/Void Claims
  - Add attachments to previously submitted Claims
  - Check Claims status
  - View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP)
  - Create and manage Claim Templates
  - Create and submit a Claim Appeal with attached files
- Prior Authorizations/Service Requests
  - Create and submit Prior Authorization/Service Requests
  - Check status of Authorization/Service Requests
- View HEDIS® Scores and compare to national benchmarks
- View a roster of assigned Molina Members for Primary Care Providers (PCPs)
- Download forms and documents
- Send/receive secure messages to/from Molina

## Balance Billing

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

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Molina to the Provider. Balance billing a Molina Member for Covered Services is prohibited, other than for the Member's applicable copayment, coinsurance and deductible amounts.

## **Member Rights and Responsibilities**

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

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

## **Member Information and Marketing**

Any written informational or marketing materials directed to Molina Members must be developed and distributed in a manner compliant with all State and Federal Laws and regulations and approved by Molina prior to use.

Please contact your Provider Services representative for information and review of proposed materials.

## **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 section of this Provider Manual.

## **Member Cost Share**

Providers should verify the Molina Member's cost share status prior to requiring the 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).

## **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 and Interdisciplinary Care Team (ICT) 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 Health Care 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 is found on the Molina website at [MolinaHealthcare.com](https://www.molinahealthcare.com).

Additional information regarding In-Network Laboratory Providers and In-Network Laboratory Provider patient service centers is found on the laboratory Providers' respective websites at [appointment.questdiagnostics.com/patient/confirmation](https://appointment.questdiagnostics.com/patient/confirmation) and [labcorp.com/labs-and-appointments](https://labcorp.com/labs-and-appointments).

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.

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

## Referrals

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

Providers should direct 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 and treatment 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 health.

## Pharmacy Program

Providers are required to adhere to Molina's drug formularies and prescription policies, including the Pharmacy Lock-In policies. For additional information please refer to the Pharmacy section of this Provider Manual.

## 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 as applicable
- Delivery of Patient Care Information

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

## Compliance

Providers must comply with all State and Federal Laws and regulations related to the care and management of Molina Members.

## Confidentiality of Member Health Information 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 Manual.

## 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 or statements if 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 Grievance and Appeals Process section of this Provider Manual.

## Participation in Credentialing

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

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

More information about Molina's Credentialing program, including Policies and Procedures is available in the Credentialing and Recredentialing section of this Provider Manual.

## Delegation

Delegated entities must comply with the terms and conditions outlined in Molina's Delegation Policies and Delegated Services Addendum. Please see the Delegation section of this Provider Manual for more information about Molina's delegation requirements and delegation oversight.

## Primary Care Provider Responsibilities

PCPs are responsible to:

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

### 3. CULTURAL COMPETENCY AND LINGUISTIC SERVICES

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#### 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 U.S. 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 orientations, ages, and religions as well as those with disabilities in a manner that recognizes values, affirms and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on cultural competency and linguistic services is available at [MolinaHealthcare.com](http://MolinaHealthcare.com), from your local Provider Services representative and by calling Molina Provider Services at (833) 685-2103.

#### Non-discrimination of Health Care Service Delivery

Molina complies with the guidance set forth in the final rule for Section 1557 of the ACA, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina website home pages. All Providers who join the Molina Provider Network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Molina requires Providers to deliver services to Molina Members without regard to race, creed, ethnicity, national origin, religion, gender, gender identity, age, mental or physical disability, sexual orientation, genetic information, health status, physical or mental ability (except where medically indicated) or source of payment. Providers must post a non-discrimination notification in a conspicuous location in their office along with translated non-English taglines in the top 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/Independent Physician Associations (IPA) may not limit their practices because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.

Providers can refer Molina Members who are complaining of discrimination to the Molina Civil Rights Coordinator at: (866) 606-3889, or TTY, 711.

Members can also email the complaint to [civil.rights@MolinaHealthcare.com](mailto:civil.rights@MolinaHealthcare.com).

Members can mail their complaint to Molina at:

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

Members can also file a civil rights complaint with the U.S. Department of Health and Human Services, OCR. Complaint forms are available at [hhs.gov/ocr/complaints/index.html](https://hhs.gov/ocr/complaints/index.html). The form can be mailed to:

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

Members can also send it to a website through the Office for Civil Rights Complaint Portal, available at [ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf).

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

Should you or a Molina Member need more information you can refer to the Health and Human Services website: [federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority](https://www.federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority)

## Cultural Competency

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

## 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 and/or online/web-based training modules.

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

Molina Healthcare of Nevada, Inc. Medicaid and Nevada Check Up Provider Manual.  
Any reference to Molina Members means Molina Healthcare Medicaid/Nevada Check Up Members.

- Provider written communications and resource materials.
- On-site cultural competency training.
- Online cultural competency Provider training modules.
- 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](http://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.

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

## 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 (833) 685-2103. 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 minor 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 his or her 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, Quality, Healthcare Services and all other health plan functions.

Molina strongly recommends that Provider offices make assistive listening devices available for Members who are deaf and hard of hearing. Assistive listening devices enhance the sound of the Provider's voice to facilitate a better interaction with the Member.

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 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 Nurse Advice Services for Members 24 hours per day, seven days per week. The Nurse Advice Line provides access to 24-hour interpretive services. Members may call Molina's Nurse Advice Line directly: 833-685-2104, or TTY/TDD 711. The Nurse Advice Line telephone numbers are also printed on membership cards.

## 4. MEMBER RIGHTS AND RESPONSIBILITIES

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Providers must comply with the rights and responsibilities of Molina Members as outlined in the Molina Member Handbook and on the Molina website. The Member Handbook that is provided to Members annually is hereby incorporated into this Provider Manual. The most current Member Rights and Responsibilities can be accessed via the following link: [MolinaHealthcare.com/members/nv/en-us/mem/medicaid/quality/rights.aspx](https://MolinaHealthcare.com/members/nv/en-us/mem/medicaid/quality/rights.aspx)

Member Handbooks are available on Molina’s Member Website. Member Rights and Responsibilities are outlined under the heading “Member Rights and Responsibilities” within the Member Handbook document.

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 (833) 685-2103, 8 a.m. to 6 p.m. Monday through Friday excluding New Year’s Day, Martin Luther King Jr. Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day. TTY users, please call 711.

### 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.

## 5. ELIGIBILITY, ENROLLMENT, DISENROLLMENT

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### Enrollment

#### Enrollment in Medicaid and Nevada Check Up Programs

The Medicaid and Nevada Check Up eligibility determination and redetermination functions and managed care program enrollment functions are the responsibility of the Nevada Department of Health and Human Services Division of Welfare and Supportive Services (DWSS) and the Division of Health Care Financing and Policy (DHCFP).

Medicaid and Nevada Check Up Members who meet the state's eligibility requirements for participation in managed care are eligible to join Molina. Members are enrolled for a period of 12 months unless the Member becomes ineligible for the program and is disenrolled.

No eligible Member shall be refused enrollment or re-enrollment, have his/her enrollment terminated, or be discriminated against in any way based on race, color, national origin, sex, sexual orientation, gender identity, or disability. Members who contact us with an allegation of discrimination are informed of their right to file a grievance.

For information on how to file a discrimination grievance, please see the Non-discrimination of Health Care Service Delivery and section in the Cultural Competency Chapter of this Provider manual.

Molina reserves the right to not re-enroll a Member with our health plan if the Member was previously disenrolled from Molina as the result of a grievance we filed unless the Member wins an appeal of the disenrollment.

#### Medicaid Newborn Enrollment

Molina is responsible for all covered medically necessary services to the qualified newborn. All eligible newborns born to Molina Members are enrolled effective the date of birth, provided the mother of the newborn was enrolled with Molina as of the newborn's date of birth.

#### Nevada Check Up Newborn Enrollment

The Head of Household/Mother must notify the DWSS of the newborn within fourteen calendar days following the delivery in order to qualify to receive coverage from the date of birth. If the family of the newborn is a Nevada Check Up family currently receiving coverage from Molina for a sibling of the newborn, the newborn is qualified to receive coverage from the date of birth and is eligible for Nevada Check Up through Molina. If notification is not received as required by DWSS, the newborn will be enrolled as of the first day of the next administrative month from the date of notification. If the mother has other health insurance coverage that provides for 30 calendar days of coverage for the



newborn, the newborn will be enrolled as of the first day of the next administrative month. If the coverage extends beyond that 30-calendar day period, the child will not be eligible for Nevada Check Up until after the insurance expires and the child's eligibility is determined under Nevada Check Up eligibility rules.

## Eligibility Verification

### Medicaid and Nevada Check Up Programs

The State of Nevada, through the DWSS determines eligibility for the Medicaid and Nevada Check Up 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 Medicaid and Nevada Check Up Programs

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

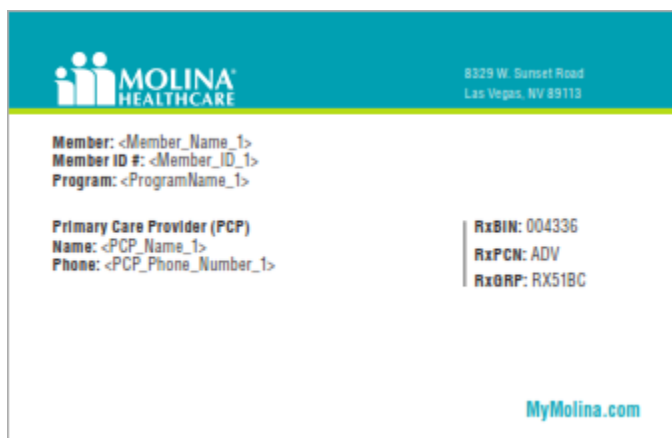
- Molina Provider Services at (833) 685-2103
- Availity Provider Portal [Provider.MolinaHealthcare.com](http://Provider.MolinaHealthcare.com)

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

## Identification Cards

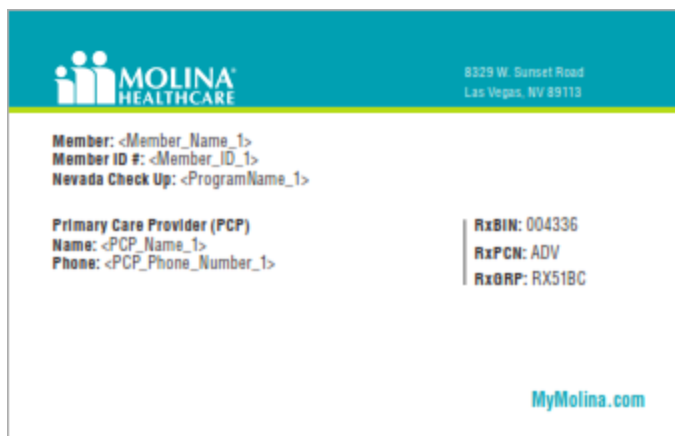
### Molina Sample Member ID Cards

#### Medicaid Program:



#### Nevada Check Up:

Molina Healthcare of Nevada, Inc. Medicaid and Nevada Check Up Provider Manual.  
Any reference to Molina Members means Molina Healthcare Medicaid/Nevada Check Up Members.



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

If a Nevada Medicaid or Nevada Check Up eligible Indian recipient request to disenroll from Molina, the disenrollment will be effective no later than the first day of the second administrative month after which all covered medically necessary services will be reimbursed by FFS.

A Member may request disenrollment for good cause at any time. Member must contact Molina orally or in writing for permission to disenroll. Good cause is defined as:

- The Member moves out of the service area
- Molina does not, because of moral or religious objections, cover the service the Member seeks.
- The Member needs related services to be performed at the same time; not all related services are available within the network; and the Member’s PCP or another Provider determine that receiving the services separately would subject the Member to unnecessary risk.
- Other reasons, including but not limited to, poor quality of care, lack of access to covered services, lack of access to Providers experienced in dealing with the Member’s health care needs or when the State imposes intermediate sanctions, and if the State has notified Molina to terminate their contract.

The effective date of disenrollment will be based on the monthly administrative cut-off date but not later than the first day of the second month in which the enrollee makes the request to disenroll. The Member must continue to receive care from Molina until the effective date of disenrollment.

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

## PCP Assignment

Molina Members are allowed to select an in-network PCP at the time of enrollment. If no PCP is selected, one will be assigned.

## PCP Changes

Members may change their PCP at any time with the change being effective on the first day of the month following the date of the Member's request. PCP changes requested in the first month of Member's enrollment can be backdated to the first of the month. Members who wish to change their PCP may call Molina Member Services at (833) 685-2102. Members may also manage their health care any time via the Member Portal available at MyMolina.com. Members may use the Member Portal to change their PCP, update their contact information, request a new ID card, and view service history.

## 6. BENEFITS AND COVERED SERVICES

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This section provides an overview of the medical benefits and Covered Services for Molina Medicaid and Nevada Check Up Members covered directly by Molina or through Subcontractors to ensure all Medically Necessary services are covered as described under the Nevada Medicaid and Nevada Check Up State plan. Some benefits may have limitations. If there are questions as to whether a service is covered or requires prior authorization please reference the benefits and prior authorization tools located on the Molina website and Provider Portal or contact Molina at (833) 685-2103, 8 a.m. to 6 p.m. Monday through Friday excluding New Year's Day, Martin Luther King Jr. Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day.

### Member Cost Sharing

Cost Sharing is the Deductible, Copayment, or Coinsurance that Members must pay for Covered Services provided under their Molina plan. The Cost Sharing amount Members will be required to pay for each type of Covered Service is summarized on the Member's ID card. Additional detail regarding Cost Sharing listed in the Summary of Benefits.

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

### Service Covered by Molina

Molina covers the services and managed care benefits package described in the Summary of Benefits documentation and as outlined in the Nevada Medicaid and Nevada Check Up state plan. If there are questions as to whether a service is covered or requires prior authorization, please reference the benefits and prior authorization tools located on the Molina website and Provider Portal or contact Molina at (833) 685-2103, 8 a.m. to 6 p.m. Monday through Friday excluding New Year's Day, Martin Luther King Jr. Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day.

### Link(s) to Summary of Benefits

The following web link(s) provides access to the Summary of Benefits guides along with access to the Nevada Medicaid and Nevada Check Up State Plan for the Medicaid programs offered by Molina in Nevada. [MolinaHealthcare.com](https://www.molinahealthcare.com)

## Obtaining Access to Certain Covered Services

### Non-Preferred Drug Exception Request Process

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

- For a Standard Exception Request, the Member and/or Member's Representative and the prescribing Provider will be notified of Molina's decision within 24 hours of receiving the complete request.
- If the initial request is denied, a notice of denial will be sent in writing to the Member and prescriber within 24 hours of receiving the complete request.
- Members will also have the right to appeal a denial decision, per any requirements set forth by the state.
- Molina will allow a 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 72-hour option is utilized. This procedure will not be allowed for routine and continuous overrides.

### Specialty Drug Services

Many self-administered and office-administered injectable products require prior authorization. In some cases, they will be made available through a vendor, designated by Molina. More information about our prior authorization process, including a link to the Prior Authorization Request Form, is available in the Healthcare Services section of this Manual. Physician administered drugs require the appropriate 11-digit NDC with the exception of vaccinations or other drugs as specified by CMS.

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

### Injectable and Infusion Services

Many self-administered and office-administered injectable products require Prior Authorization (PA). In some cases, they will be made available through a vendor, designated by Molina. More information about our Prior Authorization process, including a link to the PA request form, is available in the Pharmacy section of this Provider Manual.

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

## Access to Behavioral Health Services

Members in need of Behavioral Services can be referred by their PCP for services or Members can self-refer by calling Molina's Behavioral Health department. Molina's Nurse Advice Line is available 24 hours a day, seven days a week for mental health or substance abuse needs. The services Members receive will be confidential. Additional detail regarding Covered Services and any limitations can be obtained in the Summary of Benefits linked above, or by contacting Molina.

## Emergency Mental Health or Substance Abuse Services

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

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

## Out of Area Emergencies

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

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

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

## Emergency Transportation

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

## Non-Emergency Medical Transportation

For Medicaid Members, all covered medically necessary non-emergency transportation is authorized and arranged for through MTM, DHCFP's non-emergency transportation broker. Molina will coordinate with MTM if needed to ensure non-emergency transportation services are coordinated. Members who need assistance should contact MTM directly, or Molina Member services for assistance at least five business days in advance of scheduled appointments.

Non-emergency transportation is not available to Nevada Check Up Members.

## Preventive Care

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

[MolinaHealthcare.com/providers](https://www.molinahealthcare.com/providers)

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 childcare, (just well child) please call our Health Education line at (833) 685-2103.

## 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 Advisory Committee on Immunization Practices (ACIP) and prescribed by the child's PCP.

Immunization schedule recommendations from the ACIP and/or the CDC are available at the following website: [cdc.gov/vaccines/schedules/hcp/index.html](https://www.cdc.gov/vaccines/schedules/hcp/index.html)

Molina covers immunizations not covered through Vaccines for Children (VFC).

## Healthy Kids--Well Child Visits and EPSDT Guidelines

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

The screening services include:

- Comprehensive health and developmental history (including assessment of both physical and mental health development)
- Immunizations in accordance with the most current Centers for Disease Control and Advisory Committee on Immunization Practices Childhood Immunization Schedule, as appropriate
- Comprehensive unclothed physical exam
- Laboratory tests as specified by the AAP, including screening for lead poisoning
- Health education
- Vision services
- Hearing services
- Dental services
- Chiropractic Services (EPSDT Only)

When a screening examination indicates the need for further evaluation, Providers must provide diagnostic services or refer Members when appropriate without delay. Providers must provide treatment or other measures (or refer when appropriate) to correct or ameliorate defects and physical and mental illness or conditions discovered by the screening services, including medically necessary services that are not covered by the Medicaid state plan.

We need your help conducting these regular exams in order to meet the targeted State standard. Providers must use correct coding guidelines to ensure accurate reporting for EPSDT services. If you have questions or suggestions related to EPSDT or well child-care, please call our Health Education line at (833) 685-2103.

### Prenatal Care

Stage of Pregnancy	How often to see the doctor
1 month – 6 months	1 visit a month
7 months – 8 months	2 visits a month
9 months	1 visit a week

### Nurse Advice Line

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

Phone: 833-685-2104

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. 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

### 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.

### Health Education/Disease 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 along with access to educational materials. You can refer Members who may benefit from the additional education and support Molina offers. Members can request to be enrolled or dis-enrolled in these programs at any time. Our programs include:

- Asthma management
- Diabetes management
- High blood pressure management
- Heart failure
- Chronic Obstructive Pulmonary Disease (COPD) management
- Depression management
- Weight management
- Smoking/tobacco cessation
- Substance Use Disorder
- Nutrition consult program

For more information about these programs, please call (866) 472-9483 or TTY/TDD at 711 Relay.

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

## Telehealth and Telemedicine Services

Molina Members may obtain Covered Services by Participating Providers, through the use of Telehealth and Telemedicine services. Not all participating Providers offer these services. The following additional provisions apply to the use of Telehealth and Telemedicine services:

- Services must be obtained from a participating Provider.
- Services are meant to be used when care is needed now for non-emergency medical issues.
- Services are a method of accessing Covered Services, and not a separate benefit.
- Services are not permitted when the Member and Participating Provider are in the same physical location.
- Services do not include texting, facsimile or email only.

- Services include preventive and/or other routine or consultative visits during a pandemic.
- Member cost sharing associates to the Schedule of Benefits based upon the participating Provider's designation for Covered Services (i.e., Primary Care, Specialist or other Practitioner).
- Covered Services provided through store-and-forward technology, must include an in-person office visit to determine diagnosis or treatment.
- Upon at least 10 days prior notice to Provider, Molina shall further have the right to a demonstration and testing of Provider telehealth service platform and operations. This demonstration may be conducted either virtually or face-to-face, as appropriate for telehealth capabilities and according to the preference of Molina. Provider shall make its personnel reasonably available to answer questions from Molina regarding telehealth operations.

For additional information on Telehealth and Telemedicine Claims and billing, please refer to the Claims and Compensation section of this Provider Manual.

## 7. HEALTH CARE SERVICES

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### 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 utilization management program include pre-service authorization review and inpatient authorization management that includes pre-admission, admission and concurrent review, medical necessity review, and restrictions on the use of out-of-network Providers.

### Utilization Management (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 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 that 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 table below outlines the key functions of the UM program.

Eligibility and Oversight	Resource Management	Quality Management
Eligibility verification	Prior Authorization and referral management	Satisfaction evaluation of the UM program using Member and Provider input
Benefit administration and interpretation	Pre-admission, Admission and Inpatient Review	Utilization data analysis
Verification that authorized care correlates to Member's medical necessity need(s) & benefit plan	Discharge Planning and Care Transitions	Monitor for possible over- or under-utilization of clinical resources
Verifying of current Physician/hospital contract status	Staff education on consistent application of UM criteria	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 a 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);
- Determination to delay, modify, or deny payment of request (adverse determination);
- Discontinuation of a payment for a service;
- Payment for temporarily out-of-the-area renal dialysis services; and,

- Payment for Emergency Services, post stabilization care or urgently needed services.

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 payment of services to a Member.

Providers can contact Molina's Healthcare Services department at (833) 685-2103 to obtain Molina's UM Criteria.

## MCG for Cite Guideline Transparency

Molina has partnered with MCG Health to implement Cite for Care Guideline Transparency. Providers can access this feature through the Provider Portal. With MCG for Cite Guideline Transparency, 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 Care 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 Care Guideline Transparency, visit [MCG's website](#) or call (888) 464-4746.

## Medical Necessity

**“Medically Necessary”** or **“Medical Necessity”** means A health care service or product that is provided for under the Medicaid plan and is necessary and consistent with generally accepted professional standards to: diagnose, treat or prevent illness or disease; regain functional capacity; or reduce or ameliorate effects of an illness, injury or disability. The determination of Medical Necessity is based on the individual case and takes into account:

- Type, frequency, extent, body site and duration of treatment with scientifically based guidelines of national medical or health care coverage organizations or governmental agencies.
- Level of service that can be safely and effectively furnished, and for which no equally effective and more conservative or less costly treatment is available.
- Services are delivered in the setting that is clinically appropriate to the specific physical and mental/behavioral health care needs of the Member.
- Services are provided for medical or mental/behavioral reason rather than for the convenience of the recipient, the recipient's caregiver, or the health care Provider.

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.
3. Not primarily for the convenience of the patient, physician, or other health care Provider. 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.

## 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 denial 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 (PA) 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](http://MolinaHealthcare.com). Molina also offers a convenient PA Code Look Up tool on the website. This tool allows Provider to look up PA requirements by specific state/line of business.

Providers are encouraged to use the [Provider Portal](#) for prior authorization submissions. If not submitting through the Provider Portal, 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 codes.



- 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).
  - Rationale 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; with the exception of extenuating circumstances.

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 situation where 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 contractual requirements or 72 hours after we receive the initial request for service in the event a Provider indicates, or if we determine that a standard authorization decision timeframe could jeopardize a Member's life or health. For a standard authorization request, Molina makes the determination and provides notification no later than contractual requirements or 14 calendar days.

Providers who request prior authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina has a full-time Medical Director available to discuss medical necessity decisions with the requesting Provider at (833) 685-2103.

Upon approval, the requestor will receive an authorization number. The number may be provided by telephone or fax. If a request is denied, the requestor and the Member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the Provider by telephone if at all possible or by fax with confirmation of receipt if telephonic communication fails.



## Peer-to-Peer

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

A “peer” is considered a physician, physician assistant, nurse practitioner, or PhD psychologist who is directly providing care to the Member or a Medical Director on site at the facility. Calls from EHR and other similar contracted external parties, administrators, or facility UM staff are not peers and calls will not be returned.

## Requesting Prior Authorization

Notwithstanding any provision in the Provider Agreement that requires a 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](http://MolinaHealthcare.com) website:

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

**Availity Essentials:** Participating Providers are encouraged to use [Availity Essentials](#) (formally known as the Availity Portal) for prior authorization submissions whenever possible. Instructions for how to submit a prior authorization request are available on the Availity Essentials portal. The benefits of submitting your prior authorization request through Availity Essentials are:

- Create and submit Prior Authorization Requests.
- Check status of Authorization Requests.
- Receive notification of change in status of Authorization Requests.
- Attach medical documentation required for timely medical review and decision making.

**Fax:** The Prior Authorization Request Form can be faxed to Molina at: (775) 460-4900

**Phone:** Prior authorizations can be initiated by contacting Molina’s Healthcare Services department at (833) 685-2103. It may be necessary to submit additional documentation before the authorization can be processed.

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

Molina Healthcare of Nevada, Inc.  
Attn: Healthcare Services Dept.  
8329 W Sunset Road, Suite 100  
Las Vegas, NV 89113

Please refer to the Molina Prior Authorization Look-Up tool or the Prior Authorization Guide located on the [MolinaHealthcare.com](https://www.molinahealthcare.com) website for additional information.

## 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 meet, 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 (833) 685-2103 from 8 a.m. to 6 p.m. Monday through Friday (except for New Year's Day, Martin Luther King Jr. Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day). 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 Availability Essentials (portal) for UM access.

Molina's Nurse Advice Line is available to Members 24 hours a day, 7 days a week at (833) 685-2104. Molina's Nurse Advice Line may handle after-hours UM calls.

## Emergency Services

Emergency Services means: covered inpatient and outpatient services that are furnished by a Provider qualified to furnish such services and are 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.

Emergency Medical Condition or Emergency means: Medical condition (including labor and delivery) manifesting itself by the sudden onset of acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could reasonably be expected to result in either placing an individual's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, resulting in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or serious physical harm to another.

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 Advice line for medical advice. The 911 information is given to all Members at the onset of any call to the plan.

For Members within our service area: 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.

### **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 that observation has been tried in those patients that require a period of treatment or assessment, pending a decision regarding the need for additional care, and the observation level of care has failed. Upon discharge the Provider must provide Molina

with a copy of the 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.

When a subsequent admission to the same facility occurs within 2-30 days of discharge, and it is determined that the readmission is related to the first admission and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions.

- A readmission is considered potentially preventable if it 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.

### 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 maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process in order to provide medical care to Molina Members. 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.

## 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.

## 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 90 days or longer if necessary, for a safe transfer to another Provider as determined by Molina or its delegated Medical Group/IPA.
- High risk of second or third trimester pregnancy – The terminated Provider will continue to provide services following termination until postpartum services related to delivery are completed or longer if necessary, for a safe transfer.

For additional information regarding continuity of care and transition of Members, please contact Molina at (833) 685-2103.

## Continuity and Coordination of Provider Communication

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



## Reporting of Suspected Abuse and/or Neglect

A vulnerable adult is a person who 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 him or herself, or unable to protect him or herself 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**

#### Clark County (Las Vegas/Henderson)

Telephone: 702-399-0081

Website:

[clarkcountynv.gov/residents/family\\_services/services/child\\_protection.php](http://clarkcountynv.gov/residents/family_services/services/child_protection.php)

#### Washoe County (Reno/Sparks)

Telephone: 833-900-SAFE (7233)

Website:

[washoecounty.us/hsa/childrens\\_services/child\\_protective\\_services/reporting\\_child\\_abuse\\_and\\_neglect.php](http://washoecounty.us/hsa/childrens_services/child_protective_services/reporting_child_abuse_and_neglect.php)

#### All Other Counties:

Division of Child and Family Services:

(833) 571-1041

or

(833) 803-1183 (after hours/weekends)

### **Adult Abuse**

Adult Protective Services



Las Vegas/Clark County: (702) 486-6930  
Statewide/All other areas: (888)729-0571

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.

## PCP Responsibilities in Care Management Referrals

The Member's PCP is the primary leader of the health team involved in the coordination and direction of services for the Member. The case manager provides the PCP with the Member's 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.

## Case Manager/Care Coordinator Responsibilities

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

- Assesses the Member to determine if the Member's needs warrant care management.
- Monitors and communicates the progress of the implemented ICP to the Member's ICT as Member needs warrant.
- Serves as a coordinator and resource to the Members, their representative and ICT participants throughout the implementation of the ICP, and revises the plan as suggested and needed.
- Coordinates appropriate education and encourages the Member's role in self-management.

- Monitors progress toward the Member's achievement of ICP goals in order to determine an appropriate time for the Member's graduation from the ICM program.

## Health Management

The tools and services described here are educational support for 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 tailored to educational materials. Members are identified via Health Risk assessments and Identification and Stratification. You can also directly refer Members who may benefit from these program offerings by contacting Molina at (833) 685-2103 or by email, [CareManagement Molina Nevada@MolinaHealthcare.com](mailto:CareManagement_Molina_Nevada@MolinaHealthcare.com). Members can request to be enrolled or dis-enrolled in these programs at any time. Our programs include:

- Asthma management
- Diabetes management
- High Blood Pressure Management
- Heart failure
- Chronic Obstructive Pulmonary Disease (COPD) management
- Depression management
- Weight management
- Smoking/tobacco Cessation
- Substance Use Disorder (SUD)
- Nutrition consult program

For more information about these programs, please call (866) 472-9483 (TTY/TDD at 711 Relay).

### 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 sixth 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 [MolinaHealthcare.com](http://MolinaHealthcare.com)) within one working day of the first prenatal visit and/or positive pregnancy test. The form should be emailed to Molina at [CareManagement\\_Molina\\_Nevada@MolinaHealthcare.com](mailto:CareManagement_Molina_Nevada@MolinaHealthcare.com).

### **Member Newsletters**

Member Newsletters are posted on the [MolinaHealthcare.com](http://MolinaHealthcare.com) website twice 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 topics relevant health topics identified during our engagement with Members. Materials are available through the Member Portal, direct mail as requested, email, and the Molina My 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 newsletters, 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

Contracted Providers are notified as appropriate, when their Member is 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 Healthcare Services department toll free at (833) 685-2103.

## 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.

## Care Management (CM)

Molina provides a comprehensive CM 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 case manager/care coordinator may be licensed professionals and are educated, trained and experienced in Molina's CM program. The CM program is based on a Member advocacy philosophy, designed and administered to assure the Member value-added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes. The CM program is individualized to accommodate a Member's needs with collaboration and input from the Member's PCP. The Molina case manager/care coordinator will assess the Member upon engagement after identification for CM 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 case manager/care coordinator is responsible for assessing the Member's appropriateness for the CM program and for notifying the PCP of CM program enrollment, as well as facilitating and assisting with the development of the Member's ICP.

### Referral to Case Management

Members with high-risk medical conditions and/or other care needs may be referred by their PCP or specialty care Provider to the CM program. The case manager/care coordinator 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 case manager/care coordinator 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 CM Program for evaluation:

- High-risk pregnancy, including Members with a history of a previous preterm delivery, and Members who are pregnant and have a SUD or history of a SUD
- Catastrophic or end-stage medical conditions (e.g. neoplasm, organ/tissue transplants, End-Stage Renal Disease)
- Congestive Heart Failure (CHF)
- Coronary Arterial Disease
- Hypertension (excluding Mild Hypertension)
- Diabetes
- Chronic Obstructive Pulmonary Disease (COPD)
- Asthma
- High-Risk or High-Cost Substance Abuse Disorders; including Opioid Use Disorders
- Comorbid chronic physical health or behavioral health conditions (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
- Members transitioning from foster care and/or justice system settings
- Children with Severe Emotional Disturbance (SED) and Adults with Serious Mental Illness (SMI)
- Severe Cognitive and/or Developmental Limitation
- HIV
- Members with complex conditions such as cystic fibrosis, cerebral palsy, sickle cell anemia, etc.
- Justice involved populations/Members
- Members in Supportive Housing
- Homeless/transient status

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

Phone: (833) 685-2103

Email: [CareManagement\\_Molina\\_Nevada@MolinaHealthcare.com](mailto:CareManagement_Molina_Nevada@MolinaHealthcare.com)

## 8. BEHAVIORAL HEALTH

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### 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 care 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 at (833) 685-2103. Providers requesting after-hours authorization for these services should utilize the Provider Portal and fax 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.

### Required Behavioral Health Screening Tools

As part of the Utilization Management Program, Providers are required to utilize the following Behavioral Health Screening Tools. These completed tools and/or corresponding scores should be submitted with Prior Authorization requests for services.

- The American Society for Addiction Medicine (ASAM) for substance abuse services for Medical Necessity review for all populations ages seven (7) and older;
- ESPDT criteria when evaluating service requests for children;
- Level of Care Utilization System (LOCUS) scores for Mental Health Services for Medical Necessity reviews for Members age eighteen (18) and older;
- Child and Adolescent Level of Care Utilization System (CALOCUS) scores for Mental Health services for Medical Necessity reviews for children and adolescents age six (6) through seventeen (17); and
- Either the Early Childhood Services Intensity Instrument (ECSII) or Children and Adolescents Needs and Strengths (CANS) for infants, toddlers and preschoolers to determine Medical Necessity for children ages zero (0) through five (5) or another validated assessment tool with prior approval by the State.

### 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.

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

## **Seriously Emotionally Disturbed (SED) and Severely Mentally Ill (SMI) Members**

Providers must ensure that the parent/guardian of a minor Member who is referred for SED assessment, or/and (an) adult who is referred for SMI assessment, is fully informed of the reason why the assessment is necessary and must obtain authorization for the minor Member's parent/guardian or from the adult Member or Member's personal representative to conduct the assessment and to release the determination to the State and/or its designee.

Molina, and Molina's sub-contractors and in network Providers have the authority to make SED and SMI determinations for Molina Members. SED or SMI determinations made by authorized entities referenced in Chapter 400 of the MSM will be considered valid for recipients who transition from FFS to managed care. Likewise, determinations made by Molina or Molina's identified subcontractors or network Providers will be considered valid for Members who transition from managed care to FFS. SED or SMI determinations made by appropriately licensed mental health practitioners within the 12-month period preceding initial Medicaid eligibility will be considered valid for either FFS recipients or Members.

## **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 among all Providers on the Member's treatment team. Behavioral Health, Primary Care, and other specialty Providers shall collaborate and coordinate care between each other for the benefit of the Member. Collaboration of the treatment team will increase the communication of valuable clinical information, enhance the Member's experience with service delivery, and create opportunity for optimal health outcomes.



Molina's Case Management Program may assist in coordinating care and communication among all Providers of a Member's treatment team. Please refer to the Care Management section in the Health Care Services chapter for more.

## Care Management

Molina's Case Management/Care Coordination team includes licensed nurses and clinicians with behavioral health experience to support Members with mental health and Substance Use Disorder (SUD) needs. Members with high-risk psychiatric, medical or psychosocial needs may be referred by a Behavioral Health Provider to the Care Management Program. Behavioral Health case managers/care coordinator are available to Members 24 hours per day, 7 days per week by contacting Molina at (833) 685-2102.

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

Phone: (833) 685-2103

Email: [CareManagement\\_Molina\\_Nevada@MolinaHealthcare.com](mailto:CareManagement_Molina_Nevada@MolinaHealthcare.com)

Additional information on the Care Management Program can be found in the Care Management subsection found in the Health Care Services chapter of this Provider Manual.

## Responsibilities of Behavioral Health Providers

Molina promotes collaboration between 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 SUD 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 that Members are able to obtain needed health services within the acceptable appointment timeframes. Please see the Access to Care section of the Quality chapter 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 calendar days of the discharge date. If a Member misses a behavioral health appointment, the Behavioral Health Provider must 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

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Any reference to Molina Members means Molina Healthcare Medicaid/Nevada Check Up Members.

experiencing psychological distress may access the Behavioral Health Crisis Line by calling the Member Services number as listed on the back of the Molina Member ID Card: 833-685-2102.

## **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 toolkit 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](https://MolinaHealthcare.com) Provider website.

## 9. QUALITY

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### Maintaining Quality Improvement Processes and Programs

Molina works with Members and Providers to maintain a comprehensive Quality Improvement Program. You can contact the Molina Quality department at (833) 685-2103.

The address for mail requests is:

Molina Healthcare of Nevada, Inc.  
Attn: Quality Department  
8329 W Sunset Road, Suite 100  
Las Vegas, NV 89113

This Provider 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 requirements and accreditation standards. The Quality Improvement Program provides structure and outlines specific activities designed to improve the care, service and health of our Members. In our quality program description, we describe our program governance, scope, goals, measurable objectives, structure and responsibilities.

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

- Have a Quality Improvement Program 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.
- Cooperate with Molina's quality improvement activities that are designed to improve quality of care and services and Member experience.
- Allow Molina to collect, use and evaluate data related to Provider performance for quality improvement activities, including but not limited to focus areas, such as clinical care, care coordination and management, service, and access and availability.
- 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 care 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) to identify areas that have the potential for improving health care quality to reduce the incidence of events.

## Quality of Care

Molina has established a 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.
- Molina is not required to pay for inpatient care related to "never events."

## 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 medical record components that include but are not limited to:

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

## Medical Record Keeping Practices

Below is a list of the minimum items that 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 24 hours.
- If hard copy, 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 healthcare 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:

- Each page in the record contains the patient's name or ID number.
- Member name, date of birth, sex, race, ethnicity, primary language, disability status, marital status, address, employer, home and work telephone numbers, and emergency contact.
- Legible signatures and credentials of Provider and other staff members within a paper chart.
- All Providers who participate in the Member's care.
- Information about services delivered by these Providers.
- A problem list that describes the Member's medical and behavioral health conditions.
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other Providers.
- Prescribed medications, including dosages and dates of initial or refill prescriptions.
- Medication reconciliation within 30 days of an inpatient discharge should include evidence of current and discharge medication reconciliation and the date performed.
- Allergies and adverse reactions (or notation that none are known).
- Documentation that 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 Provider.

- Clear and thorough progress notes that state the intent for all ordered services and treatments.
- Notations regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed, 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.
- Notation concerning cigarettes, alcohol and substance abuse for patients 12 years and older.
- 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.
- A release document for each Member authorizing Molina to release medical 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 the applicable State and/or Federal agency and the External Quality Review Organization upon request.
- The medical record is available to the Member upon their request at no cost and in a timely manner (no longer than 30 days from date of request).
- When a Member changes PCPs the medical record must be forwarded to the new Provider within 10 business days from receipt of request.
- A storage system for inactive Member medical records which allows retrieval within 24 hours, is consistent with State and Federal requirements, and the record is maintained for not less than 10 years from the last date of treatment or for a minor, one year past their 20<sup>th</sup> birthday but, never less than 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 and enrollment information.
- Medical Records are protected from unauthorized access.
- Access to computerized confidential information is restricted.
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.
- Education and training for all staff on handling and maintaining protected health care information.

Additional information on medical records is available from your local Molina Quality department. For additional information regarding HIPAA please, refer to the Compliance section of this Provider Manual

## 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 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 80 percent availability for Emergency Services and 90 percent or greater for all other services. The PCP or their designee must be available 24 hours a day, seven days a week to Members.

## 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

Appointment Types	Standard
Routine PCP (excludes visits to monitor chronic condition if less frequent visits are indicated)	Within 2 weeks
Medically Necessary PCP	Within 2 calendar days
PCP Urgent Care	Same day
After Hours Care	24 hours/day; 7 day/week availability
Specialty Care Same Day Emergency	Within 24 hours of referral
Specialty Care- Urgent	Within 3 calendar days of referral
Specialty Care-Routine	Within 30 calendar days of referral
Well-child Preventive Care	Within 14 calendar days
Adult Preventive Care	Within 21 calendar days
Prenatal Care Initial Visit	First Trimester: within 7 calendar days of request Second Trimester: within 7 calendar days of request Third Trimester: within 3 calendar days of request High Risk: within 3 calendar days of identification of high risk, or immediately if emergency exists
Private Duty Nursing/Home Health/Personal Care Urgent	Same Day
Private Duty Nursing/Home Health/Personal Care Non-Urgent	Within 14 calendar days

## Behavioral Health Appointment

Appointment Types	Standard
Life Threatening Emergency	Immediately



Appointment Types	Standard
Non-life-threatening Emergency	Within 6 hours
Urgent Care	Within 72 hours
Behavioral Health/Substance Use Disorder Providers Routine Visit	Not to exceed 30 calendar days
Follow-up Routine Care Visit	Within 2 weeks

Additional information on appointment access standards is available from your local Molina Quality department.

## Office Wait Time

For scheduled appointments, the wait time in offices should not exceed one hour. 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 24-hour telephone 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. Voicemail alone after-hours is not acceptable.

## Women's Health Access

Molina allows Members the option to seek obstetric and gynecological care from an in-network obstetrician or gynecologist or directly from a participating PCP designated by Molina as providing obstetrical and gynecological services. Member access to obstetrical and gynecological services is monitored to ensure Members have direct access to participating Providers for obstetrical and gynecological services. Gynecological services must be provided when requested regardless of the gender status of the Member.

Additional information on access to care is available from your local Molina Quality department.

## Monitoring Access for Compliance with Standards

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

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

1. Provider access studies/surveys – At least annual Provider office assessment of appointment availability, after-hours access, Provider ratios, and geographic access.
2. Member complaint data – assessment of Member complaints related to access and availability of care.
3. Member satisfaction survey – evaluation of 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 initiated when performance goals are not met and for identified Provider-specific and/or organizational trends. Performance goals are reviewed and approved annually by the Quality Improvement Committee.

## Quality of Provider Office Sites

Molina Providers are to maintain office-site and medical record keeping practices standards. Molina continually monitors Member appeals and complaints/grievances for all office sites to determine the need of an office site visit and will conduct office site visits as needed. 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 as applicable 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 are not limited to, an evaluation of office site cleanliness, appropriateness of lighting, and patient safety as needed.

### Adequacy of Waiting and Examining Room Space

During the site visit as required, 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 10 or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, and contracts evidence hazardous waste management.
- 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 are 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 directive requirements of the states in which the organization provides services. Responsibilities include ensuring Members receive

information regarding advance directives and that contracted Providers and facilities uphold executed documents.

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

- **Durable Power of Attorney for Health Care:** allows an agent to be appointed to carry out health care decisions.
- **Living Will:** allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration.

**When There 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, 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 or are directed to the CaringInfo website at [caringinfo.org/planning/advance-directives/](http://caringinfo.org/planning/advance-directives/) for forms available to download.

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

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

## **EPSDT Services to Enrollees Under 21 Years of Age**

Molina maintains systematic and robust monitoring mechanisms to ensure all required Early and Periodic Screening Diagnostic and Treatment (EPSDT) Services to Enrollees under 21 years of age are timely according to required preventive guidelines. All Enrollees under 21 years of age should receive preventive, diagnostic and treatment services at intervals as set forth in Section 1905 (R) of the Social Security Act. Molina's Quality or the Provider Services 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.

## **Well Child/Adolescent Visits**

Visits consist of age-appropriate components that include but are not limited to:

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

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 medically necessary regardless of state Medicaid coverage.

## 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 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 and Case Management

The Molina Health Management and Case Management programs provide for the stratification, identification, assessment, and implementation of appropriate interventions for Members with chronic diseases.

For additional information, please see the Health Management and Case Management headings in the Healthcare Services section of this Provider 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. Clinical Practice Guidelines are reviewed at least annually, and more frequently as needed when clinical evidence changes, and approved by the Quality Improvement Committee.

Molina Clinical Practice Guidelines include the following:

- Acute Stress and Post-Traumatic Stress Disorder (PTSD)
- Anxiety/Panic Disorder
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Bipolar Disorder
- Children with Special Health Care Needs
- Chronic Kidney Disease

- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Failure
- Hypertension
- Obesity
- Opioid Management
- Perinatal/Prenatal/Postnatal Care
- Schizophrenia
- Sickle Cell Disease
- Substance Use 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 [MolinaHealthcare.com/providers/nv/medicaid/health/quality.aspx](https://MolinaHealthcare.com/providers/nv/medicaid/health/quality.aspx). Individual Providers or Members may request copies from your local Molina Quality department.

## Preventive Health Guidelines

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

- Adult Preventive Services
- Preventive Pediatric Health Care
- Immunization schedules for children and adolescents.
- Immunization schedules for adults.

All guidelines are updated at least annually and more frequently as needed when clinical evidence changes and are approved by the Quality Improvement Committee. On an annual basis, Preventive Health Guidelines are distributed to Providers at [MolinaHealthcare.com](https://MolinaHealthcare.com) and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Provider Newsletter.

## Cultural and Linguistic Services

Molina 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 Provider Manual.

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Any reference to Molina Members means Molina Healthcare Medicaid/Nevada Check Up Members.



## 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 Satisfaction Assessment
- Provider Satisfaction Survey
- 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 or by visiting our website at [MolinaHealthcare.com](https://www.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. The results 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 Satisfaction Assessment

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

## Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS® Survey 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 used 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.
- 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 the Provider Portal. There are a variety of resources, including HEDIS® CPT/CMS-approved diagnostic and procedural code sheets. To obtain a current list of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey Star Ratings measures, contact your local Molina Quality department.

HEDIS® and CAHPS® are registered trademarks of the National Committee for Quality Assurance (NCQA).

## 10. RISK ADJUSTMENT MANAGEMENT PROGRAM

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### What is Risk Adjustment?

The Centers for Medicare & Medicaid Services (CMS) defines Risk Adjustment as a process that helps accurately measure the health status of a plan's membership based on medical conditions and demographic information.

This process helps ensure health plans receive accurate payment for services provided to Molina Members and prepares for resources that may be needed in the future to treat Members who have multiple clinical conditions.

### Why is Risk Adjustment Important?

Molina relies on our Provider Network to take care of our Members based on their health care needs. Risk Adjustment looks at a number of clinical data elements of a Member's health profile to determine any documentation gaps from past visits and identifies opportunities for gap closure for future visits. In addition, Risk Adjustment allows us to:

- Focus on quality and efficiency.
- Recognize and address current and potential health conditions early.
- Identify Members for Case Management referral.
- Ensure adequate resources for the acuity levels of Molina Members.
- Have the resources to deliver the highest quality of care to Molina Members.

### Your Role as a Provider

As a Provider, your complete and accurate documentation in a Member's medical record and submitted Claims are critical to a Member's quality of care. We encourage Providers to code all diagnoses to the highest specificity as this will ensure Molina receives adequate resources to provide quality programs to you and our Members.

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

- Address clinical data elements (e.g. diabetic patient needs an eye exam or multiple comorbid conditions) provided by Molina and reviewed with the Member.
- Be compliant with CMS correct coding initiative.
- Use the correct ICD-10 code by coding the condition to the highest level of specificity.
- Only use diagnoses codes confirmed during a Provider visit with a Member. The visit may be face-to-face or telehealth depending on State or CMS requirements.
- Contain a treatment plan and progress notes.
- Contain the Member's name and date of service.
- Have the Provider's signature and credentials.

## **RADV Audits**

As part of the regulatory process, State and/or Federal agencies may conduct Risk Adjustment Data Validation (RADV) audits to ensure that the diagnosis data submitted by Molina is appropriate and 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 submit medical records in a timely manner to validate the previously submitted data.

## **Contact Information**

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

## 11. COMPLIANCE

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### 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 the Compliance Department in its efforts to detect, deter, and prevent fraud, waste, and abuse by conducting investigations aimed at identifying suspect activity and reporting these findings to the appropriate regulatory and/or Law enforcement agency.

#### Mission Statement

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

#### Regulatory Requirements

##### Federal False Claims Act

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

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

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

The act 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 Medicare/Medicaid funds either by fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and State Laws pertaining to submitting false Claims.
- How Providers will detect and prevent fraud, waste, and abuse.
- Employee protection rights as whistleblowers.

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

Whistleblower protections state that employees who 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 payments until compliance is met. Molina will take steps to monitor Molina contracted Providers to ensure compliance with the Law.

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

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

**Sarbanes-Oxley Act of 2002** – Requires certification of financial statements by both the Chief Executive Officer and the Chief Financial Officer. The Act states that a corporation must assess the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

## Definitions

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

**Waste:** means 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 State and Federal health care programs.

**Abuse:** means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to State and Federal health care programs, 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 State and Federal health care programs. (42 CFR § 455.2)

## Examples of Fraud, Waste and Abuse by a Provider

The types of questionable Provider schemes investigated by 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 Provider has a financial relationship. (Stark Law)
- Altering Claims and/or medical record documentation in order to get a higher level of reimbursement.
- Balance billing a 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 State and Federal health care programs.
- Doctor shopping, which occurs when a Member consults a number of Providers for the purpose of inappropriately obtaining services.
- Falsifying documentation in order to get services approved.
- Forgery related to health care.
- Prescription diversion, which occurs when a Member obtains a prescription from a Provider for a condition that they 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 and to detect fraud, waste and abuse. If the Claims Examiner suspects fraudulent, abusive or wasteful billing practices, the billing practice is documented and reported to the Compliance Department.

The Claims payment system utilizes system edits and flags to validate those elements of Claims are billed in accordance with standardized billing practices; ensure that Molina Healthcare of Nevada, Inc. Medicaid and Nevada Check Up Provider Manual. Any reference to Molina Members means Molina Healthcare Medicaid/Nevada Check Up Members.



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 & 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 Medically Unlikely Edit (MUE) table, the National Correct Coding Initiative (NCCI) files, Local Coverage Determination/National Coverage Determination (LCD/NCD), and State-specific policy manuals and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).

Additionally, 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 Provider Manual are incorporated into the Provider Agreement, and are intended to supplement, rather than diminish, any and all other rights and remedies that may be available to Molina 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 visit 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 cases of 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 24 hours a day, seven days a week, 365 days a year. When you make a report, you can choose to remain confidential or anonymous. If you choose to call 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](https://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 Nevada, Inc.  
Attn: Compliance  
8329 W. Sunset Road, Suite 100  
Las Vegas, NV 89113

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:

Office of the Attorney General  
Medicaid Fraud Control Unit  
100 North Carson St.  
Carson City, NV 89701

Complaint form available at: [ag.nv.gov/Complaints/File\\_Complaint/](https://ag.nv.gov/Complaints/File_Complaint/)

## HIPAA Requirements and Information

### HIPAA (The Health Insurance Portability and Accountability Act)

#### 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 Member's 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)

#### 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 Molina Healthcare of Nevada, Inc. Medicaid and Nevada Check Up Provider Manual. 82  
Any reference to Molina Members means Molina Healthcare Medicaid/Nevada Check Up Members.

patchwork of Laws that Providers must comply with. In general, most health care Providers are subject to various Laws and regulations pertaining to privacy of health information, including, without limitation, the following:

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

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

### Uses and Disclosures of PHI

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

1. A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of services<sup>2</sup>.
2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:
  - Quality Improvement
  - Disease Management

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<sup>1</sup>See, Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule.

<sup>2</sup>See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

- Case 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.

### **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**

Molina Healthcare of Nevada, Inc. Medicaid and Nevada Check Up Provider Manual.  
Any reference to Molina Members means Molina Healthcare Medicaid/Nevada Check Up Members.

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-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 cybersecurity measures. Providers should recognize that identity theft - both financial and medical - is a rapidly growing problem and that their patients trust their health care Providers to keep their most sensitive information private and confidential.

Medical identity theft is an emerging threat in the health care industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity - such as health insurance information - without the person's knowledge or consent to obtain health care services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to 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](http://MolinaHealthcare.com) for additional information regarding HIPAA standard transactions.

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

## Code Sets

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

## National Provider Identifier (NPI)

Providers must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to 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 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 does not reimburse Providers for copies of PHI related to our 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/Grievance
- Anti-Fraud Program Review
- Quality of Care Issues
- Regulatory Audits
- Risk Adjustment
- Treatment, Payment and/or Operation Purposes
- Collection of HEDIS® medical records

## Business Continuity Plan (BCP)

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

The Provider Business Continuity Plan will include:

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

The Provider will notify Molina of a disruption to the services or activation of business continuity plans within two hours and will provide Molina with regular updates on the situation and actions taken to resolve the issue, until normal services have been resumed.

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

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

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

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

## Definitions

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

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

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

## Cybersecurity Requirements

Note: This section (Cybersecurity Requirements) is only applicable to Providers who are delegated Providers and have been delegated by Molina to perform a health plan function.

1. Provider shall comply with the following requirements and permit Molina to audit such compliance as required by law or any enforcement agency.
2. The following terms are defined as follows:
  - I. “Consumer” means an individual who is a State resident, whose Nonpublic Information is in Molina’s possession, custody or control and which Provider maintains, processes, stores or otherwise has access to such Nonpublic Information.
  - II. “Cybersecurity Event” means any act or attempt, successful or, to the extent known by Provider, unsuccessful, to gain unauthorized access to, disrupt or misuse an Information System or Nonpublic Information stored on such Information System. The ongoing existence and occurrence of attempted but Unsuccessful Security Incidents shall not constitute a Cybersecurity Event under this definition. “Unsuccessful Security Incidents” are activities such as pings and other broadcast attacks on Provider’s firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of Molina Nonpublic Information or sustained interruption of service obligations to Molina.
  - III. “Information System” or “Information Systems” means a discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination or disposition of electronic Nonpublic Information, as well as any specialized system such as industrial or process controls systems, telephone switching and private branch exchange systems, and environmental control systems.
  - IV. “Nonpublic Information” means information that is not publicly available information and is one of the following:

- (a) business related information of Molina the tampering with which, or unauthorized disclosure, access, or use of which, would cause a material adverse impact to the business, operations, or security of Molina;
  - (b) any information concerning a Consumer that because of the name, number, personal mark, or other identifier contained in the information can be used to identify such Consumer, in combination with any one or more of the following data elements:
    - (i) social security number;
    - (ii) driver's license number, commercial driver's license or state identification card number;
    - (iii) account number, credit or debit card number;
    - (iv) security code, access code, or password that would permit access to a Consumer's financial account; or
    - (v) biometric records;
  - (c) any information or data, except age or gender, in any form or medium created by or derived from a health care Provider or a Consumer, that can be used to identify a particular Consumer, and that relates to any of the following:
    - (i) the past, present, or future physical, mental or behavioral health or condition of a Consumer or a member of the Consumer's family;
    - (ii) the provision of health care to a Consumer; or
    - (iii) payment for the provision of health care to a Consumer.
- V. "State" means the State of Nevada.
3. Provider shall implement appropriate administrative, technical, and physical measures to protect and secure the Information Systems and Nonpublic Information, as defined herein, that are accessible to, or held by, the Provider. Implementation of the foregoing measures shall incorporate guidance issued by the State Department of Insurance, as appropriate.
  4. Provider agrees to comply with all applicable laws governing Cybersecurity Events. Molina will decide on notification to affected Consumers or government entities. Upon Molina's prior written request, Provider agrees to assume responsibility for informing all such Consumers in accordance with applicable law.
  5. In the event of a Cybersecurity Event, Provider shall notify Molina's Chief Information Security Officer of such Cybersecurity Event by telephone and email (as provided below) as promptly as possible, but in no event later than seventy-two (72) hours from a determination that a Cybersecurity Event has occurred. A follow-up notification shall be provided by mail, at the address indicated below. Notification to Molina's Chief Information Security Officer shall be provided to:
 

Molina Chief Information Security Officer  
 Telephone: 844-821-1942  
 Email: [CyberIncidentReporting@molinahealthcare.com](mailto:CyberIncidentReporting@molinahealthcare.com)  
 Molina Chief Information Security Officer  
 Molina Healthcare, Inc.  
 200 Oceangate Blvd., Suite 100  
 Long Beach, CA 90802

6. Upon Provider's notification to Molina of a determination of a Cybersecurity Event, Provider must promptly provide Molina any documentation required and requested by Molina to complete an investigation, or, upon written request by Molina, Provider shall complete an investigation pursuant to the following requirements:
  - (a) determine whether a Cybersecurity Event occurred;
  - (b) assess the nature and scope of the Cybersecurity Event;
  - (c) identify Nonpublic Information that may have been involved in the Cybersecurity Event; and
  - (d) perform or oversee reasonable measures to restore the security of the Information Systems compromised in the Cybersecurity Event to prevent further unauthorized acquisition, release, or use of the Nonpublic Information.
7. Provider shall maintain records concerning all Cybersecurity Events for a period of at least five (5) years from the date of the Cybersecurity Event or such longer period as required by applicable laws and produce those records upon request of Molina.
8. Provider must provide to Molina the documentation required and requested by Molina in electronic form. Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to Molina concerning the Cybersecurity Event. The information provided to Molina in the initial and subsequent notices must include as much of following information known to Provider at the time of the notification:
  - (a) the date of the Cybersecurity Event;
  - (b) a description of how the information was exposed, lost, stolen, or breached, including the specific roles and responsibilities of Provider, if any;
  - (c) how the Cybersecurity Event was discovered;
  - (d) whether any lost, stolen, or breached information has been recovered and if so, how this was done;
  - (e) the identity of the source of the Cybersecurity Event;
  - (f) whether Provider has filed a police report or has notified any regulatory, governmental or law enforcement agencies and, if so, when such notification was provided;
  - (g) a description of the specific types of information acquired without authorization, which means particular data elements including, for example, types of medical information, types of financial information, or types of information allowing identification of the Consumer;
  - (h) the period during which the Information System was compromised by the Cybersecurity Event;
  - (i) the number of total Consumers in the State affected by the Cybersecurity Event;
  - (j) the results of any internal review identifying a lapse in either automated controls or internal procedures, or confirming that all automated controls or internal procedures were followed;
  - (k) a description of efforts being undertaken to remediate the situation which permitted the Cybersecurity Event to occur;

- (l) a copy of Provider's privacy policy and if requested by Molina, the steps that Provider will take to notify Consumers affected by the Cybersecurity Event;  
and
- (m) the name of a contact person who is both familiar with the Cybersecurity Event and authorized to act on behalf of Provider.

In the event provisions of this Section conflict with provisions of any other agreement between Molina and Provider, the stricter of the conflicting provisions will control.

## 12. CLAIMS AND COMPENSATION

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Payor ID	MLNNV
Provider Portal	<a href="http://Provider.MolinaHealthcare.com">Provider.MolinaHealthcare.com</a>
Clean Claim Timely Filing	180 days (in state Providers) 365 days (out of state Providers)

### 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 [Provider Portal](http://Provider.MolinaHealthcare.com)
- Submit Claims to Molina via your regular EDI clearinghouse

### Availity Provider Portal

The [Availity Provider Portal](http://Availity.MolinaHealthcare.com) is a no cost online platform that offers a number of Claims processing features:

- Submit Professional (CMS1500) and Institutional (UB04) Claims with attached files
- Correct/Void Claims
- Add attachments to previously submitted Claims
- Check Claims status
- View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP)
- Create and manage Claim Templates
- Create and submit a Claim Appeal with attached files

### Clearinghouse

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

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 contact your local clearinghouse representative if you experience any problems with your transmission.

### **EDI Claims Submission Issues**

Providers who are experiencing EDI Submission issues should work with their clearinghouse to resolve this issue. If the Provider's clearinghouse is unable to resolve, the Provider may email Molina at [EDI.Claims@MolinaHealthcare.com](mailto:EDI.Claims@MolinaHealthcare.com) for additional support.

### **HIPAA 5010 Transaction Compliance Standards Implementation**

Molina accepts and issues all Electronic Data Interchange (EDI) HIPAA transactions in Version 5010 format, regulated by CMS.

### **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 in-state Providers to Molina within 180 calendar days after the discharge for inpatient services or the Date of Service for outpatient services. Claims from out of state Providers must be submitted within 365 calendar days after the date of discharge for inpatient services or the Date of Service for outpatient services, unless otherwise noted in the Provider Agreement. If Molina is not the primary payer under coordination of benefits or third-party liability, Provider must submit Claims to Molina within 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.

### **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 must utilize electronic billing through a clearinghouse Availity

Essentials [Provider 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). For Members assigned to a delegated medical group/IPA that processes its own Claims, please verify the Claim Submission instructions on the Member's Molina ID card.

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.

## Required Elements

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

The following information must be included on every Claim:

### CMS 1500

CMS 1500 Field #	NV Billing Requirement	CMS 1500 Field Name and Instructions
1	Not Required	<b>Type of health insurance coverage:</b> Check only the type of health coverage applicable to the claim. This field indicated the payer to whom the claim is being field. Enter "X" in the box noted "Other."
1a	Required	<b>Insured ID Number:</b> identification number on the Member's Health Plan I.D. Card
2	Required	<b>Patient's Name:</b> Enter the patient's name as it appears on the Member's Health Plan I.D. card. Do not use nicknames
3	Required	<b>Patient's Birth Date, Sex:</b> Enter the patient's eight (8) digit date of birth (MM/DD/YYYY), and mark the appropriate box to indicate the patient's sex/gender.
4	Recommended	<b>Insured's Name:</b> Enter the patient's name as it appears on the member's Health Plan I.D. Card
5	Recommended	<b>Patient's Address, City, State, Zip Code, Telephone</b>
6	Recommended	<b>Patient relationship to insured</b>
7	Recommended	<b>Insured's Address, City, State, Zip Code, Telephone</b>
8	Not Required	<b>This field is reserved for NUCC use</b>



9	Recommended	<b>Other insured name:</b> Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured.
9a	Situational	<b>Other insured 's policy or group Number:</b> Recipient has TPL with Medicare coverage: Enter the recipient's Medicare number Recipient has TPL with commercial coverage: Enter the recipient's identifier with their primary carrier
9b	Not Required	<b>This field is reserved for NUCC use</b>
9c	Not Required	<b>This field is reserved for NUCC use</b>
9d	Situational	<b>Insurance plan name or program name:</b> REQUIRED if field 9 is completed. Enter the other insured's (name of person listed in field 9) insurance plan or program name.
10a-c	Situational	<b>Is Patient's condition related to:</b> Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line. When marked Yes, primary insurance information must then be shown in Item Number 11.
10d	Not Required	<b>Reserved for local use</b>
11	Situational	<b>Insured's policy group or FECA number</b>
11a	Situational	<b>Insured's date of birth, sex</b>
11b	Situational	<b>Other Claim ID (Designated by NUCC)</b>
11c	Situational	<b>Insurance plan name or program name</b>
11d	Situational	<b>OR WORKERS' COMPENSATION OR PROPERTY &amp; CASUALTY:</b> Required if known. Enter the claim number assigned by the payer
12	Not Required	<b>Patient's or authorized person's signature</b>
13	Not Required	<b>Insured's or authorized person's signature</b>
14	Situational	<b>Date of current illness, injury or pregnancy:</b> Enter the 6-digit (MM   DD   YY) or 8-digit (MM   DD   YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date
15	Situational	<b>If patient has had same or similar illness</b>
16	Situational	<b>Dates patient unable to work in current occupational</b>
17	Situational	<b>Name of referring Provider</b>
17a	Not Required	<b>Not Labeled</b>
17b	Situational	<b>NPI of Referring Provider:</b>
18	Situational	<b>Hospitalization dates related to current services</b>
19	Situational	<b>Additional Claim Information (Designated by NUCC)</b>
20	Not Required	
21	Required	<b>Diagnosis or nature of illness or injury:</b> Enter up to twelve (12) ICD-10 codes in the spaces indicated A through L. Please enter the codes across each line, not down.

22	Situational	<b>Resubmission Code:</b> Complete this field to adjust or void a previously paid claim. Otherwise, leave this field blank. - In the Code area, enter an adjustment or void reason code (see section Adjustment/Void reason codes for Field 22) - In the Original Reference Number area, enter the last paid Internal Control Number (ICN) of the claim Adjustment and voids apply to previously paid claims only (including zero paid claims). Resubmitting a denied claim is not considered an adjustment. 7 – Replacement of Prior Claim 8 – Void/Cancel Prior Claim
23	Situational	<b>Prior authorization number:</b> If you obtained authorization for an item on this claim, enter your authorization number in this field Enter only one authorization number per claim form. Complete additional forms if needed
24a	Required	<b>Dates of Service:</b> <i>Dates:</i> In the bottom, white half of the claim line, enter the begin (From) and end (To) dates of service. If a service was provided on one day only, enter the same date twice. In the top, shaded half of the claim line, enter qualifier N4 followed by the drug's 11-digit NDC. The first, second and third sections of the NDC (separated by hyphens on the container label) must contain 5, 4 and 2 digits, respectively, when entered on the claim form. To facilitate this, you must add leading zeros to one or more sections of the NDC if the container label does not display: - 5 digits in the first section of the NDC - 4 digits in the second section of the NDC - 2 digits in the third section of the NDC For example, using the 5-4-2 model described above: - 34-73-1 on the container label is expressed as 00034007301 on the claim - 654-3773-22 on the container label is expressed as 00654377322 on the claim - 1645-222-65 on the container label is expressed as 16457022265 on the claim - 12345-6-7 on the container label is expressed as 12345000607 on the claim - 86541-4885-77 on the container label is expressed as 86541488577 on the claim For multi-ingredient compounds, list each component separately, on its own claim line with the 11-digit NDC in this field. For more information and examples on billing physician administered drugs, see the NDC Billing Reference on the Nevada Medicaid website.
24b	Required	<b>Place of Service:</b> Use the most appropriate Place of Service code in the bottom, white half of the claim line
24c	Not Required	<b>EMG:</b> Enter Y (Yes) or N (No) to indicate if the service was an emergency.
24d	Required	<b>Procedures, services or supplies CPT/HCPCS modifier:</b> <b>CPT/HCPCS Code:</b> Enter one CPT or one HCPCS code and up to four modifiers on the bottom, white half of the claim line. In the top, shaded half of the claim line, enter the NDC quantity, i.e., the number of NDC units administered. Fractions of a unit should be expressed in decimal form using up to three decimal places. Do not include the NDC standard unit of measure on your claim, i.e., milliliters, grams or each.
24e	Required	<b>Diagnosis Pointer</b> In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A – L or multiple

		letters as applicable. ICD-9-CM or ICD-10CM diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E. Do not use
24f	Required	<b>Charges</b> Enter the charge amount for the claim line-item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line
24g	Required	<b>Dates or units</b> Enter quantity (days, visits, units). If only one service provided, enter a numeric value of one
24h	Situational	<b>EPSDT/Family Plan</b> Leave blank or enter "Y" if the services were performed as a result of an EPSDT referral.
24i	Required	<b>ID Qualifier:</b> Using NPI field in field 24j: Enter ZZ in the top, shaded half of claim line
24j	Required	<b>Rendering Provider ID:</b> NPI Users: Enter the Provider's taxonomy code in the top, shaded half of the claim line NPI Users: Enter the Provider's NPI in the bottom, white half of the claim line
25	Required	<b>Federal Tax ID Number</b>
26	Recommended	<b>Patient's account number</b>
27	Situational	<b>Accept Assignment</b>
28	Required	<b>Total charge</b> Add all amounts in column 24F. Enter the total in this field.
29	Situational	<b>Amount Paid</b>
30	Situational	<b>Balance Due</b> (Reserved for NUCC Use)
31	Required	<b>Signature of physician or supplier:</b> The billing Provider or authorized representative must sign and date this field. Original, rubber stamp and electronic signatures are accepted.
32	Situational	<b>Service Facility Location Information:</b> Service facility location information: Enter the name and full address of the location where service was rendered. If the service was rendered in the recipient's home, leave this field blank. Ambulance Providers: Do not enter From and To dates in this field.
32a	Not Required	<b>NPI #</b> Enter the 10-character NPI ID of the facility where services were rendered.
32b	Not Required	<b>Other ID #</b>
33	Required	<b>Billing Provider Info &amp; Ph #:</b> Enter the full address of the billing Provider.

## UB-04

UB Field #	NV Billing Requirement	UB Field Name and Instructions
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1	Required	<b>Billing Provider name and address</b>
2	Not Required	<b>Pay-to name and address (unlabeled on form)</b>
3a	Recommended	<b>Patient control number:</b> Although not required, you can use this field to enter the recipient's unique control number assigned by the Provider (internal patient account number).
3b	Not Required	<b>Medical/Health record number</b>
*4	Required	<b>Type of Bill:</b> Enter the appropriate type of bill code. 1st Digit – Indicating the type of facility. 2nd Digit – Indicating the type of care. 3rd Digit- Indicating the bill sequence (Frequency code). - Adjustments: Use 7 for the last digit in your Type of Bill code. - Voids: Use 8 for the last digit in your Type of Bill code.
5	Recommended	<b>Federal Tax Number</b>
6	Required	<b>Statement covers period:</b> Enter the beginning service date in the From area and the last service date in the Through area of this field. For services received on a single day, use the same From and Through dates.
7	Not Required	<b>Reserved for assignment by the NUBC</b>
8a	Not Required	<b>Patient name identifier</b>
8b	Required	<b>Patient's Name:</b> Enter the patient's last name, first name, and middle initial as it appears on the Health Plan ID card.
9a-e	Not Required	<b>Patient's Address</b>
10	Not Required	<b>Patient's Date of Birth</b>
11	Not Required	<b>Patient sex</b>
12	Required	<b>Admission/start of care date:</b> Enter the date of admission for inpatient claims and date of service for outpatient claims.
*13	Recommended	<b>Admission hour (if applicable):</b> If inpatient, indicate the hour during which the recipient was admitted. If outpatient, enter the hour the episode of care began. If no admission hour is entered for an outpatient claim, the system will default to hour 1300 (1 p.m.)
*14	Required	<b>Priority (type) of visit:</b> Indicate the priority of the admission/visit 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma
*15	Required	<b>Source of referral for admission or visit:</b> Indicate the source of referral for this admission or visit.

*16	Situational	<b>Discharge Hour (if applicable):</b> If inpatient, indicate the hour in which the recipient was discharged from inpatient care. If outpatient, enter the hour the episode of care concluded.
*17	Required	<p><b>Patient discharge status:</b> Indicate the recipient’s disposition or discharge status at the end of service for the period covered on this bill, as reported in Field 6, Statement Covers Period.</p> <p>01 Routine Discharge  02 Discharged to another short-term general hospital  03 Discharged to SNF  04 Discharged to ICF  05 Discharged to another type of institution  06 Discharged to care of home health service Organization  07 Left against medical advice  08 Discharged/transferred to home under care of a Home IV Provider  09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims)  20 Expired or did not recover  30 Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG)  40 Expired at home (hospice use only)  41 Expired in a medical facility (hospice use only)  42 Expired—place unknown (hospice use only)  43 Discharged/Transferred to a federal hospital (such as a Veteran’s Administration [VA] hospital)  50 Hospice—Home  51 Hospice—Medical Facility  61 Discharged/ Transferred within this institution to a hospital-based Medicare approved swing bed  62 Discharged/ Transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital  63 Discharged/ Transferred to a Medicare certified long-term care hospital (LTCH)  64 Discharged/ Transferred to a nursing facility certified under Medicaid but not certified under Medicare  65 Discharged/ Transferred to a Psychiatric hospital or psychiatric distinct part unit of a hospital  66 Discharged/transferred to a critical access hospital (CAH)</p>
*18-28	Situational	<b>Condition Codes:</b> If applicable, indicate conditions or events relating to this claim.
29	Situational	<b>Accident State</b>

30	Not Required	<b>Reserved for assignment by the NUBC</b>
*31-34	Situational	<b>Occurrence codes and dates:</b> REQUIRED when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing
*35-36	Situational	<b>Occurrence span codes and dates:</b> REQUIRED when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing.
37	Not Required	<b>Reserved for assignment by the NUBC</b>
38	Not Required	<b>Responsible party name and address:</b>
*39-41	Situational	<b>Value codes and amounts:</b> REQUIRED when applicable. Value codes are used to identify events relating to the bill that may affect payer processing.
*42	Required	<b>Revenue Code:</b> Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient.
*43	Situational	<p><b>Description:</b> In this field, enter qualifier N4 followed immediately by the drug's 11-digit NDC followed by a space and then the NDC quantity (not HCPCS units) of the drug. The first, second and third sections of the NDC (separated by hyphens on the container label) must contain 5, 4 and 2 digits, respectively, when entered on the claim form. Therefore, you must add leading zeros to one or more sections of the NDC if the container label does not display:</p> <ul style="list-style-type: none"> <li>- 5 digits in the first section of the NDC</li> <li>- 4 digits in the second section of the NDC</li> <li>- 2 digits in the third section of the NDC</li> </ul> <p>For example, using the 5-4-2 model described above:</p> <ul style="list-style-type: none"> <li>- 34-73-1 on the container label is expressed as 00034007301 on the claim</li> <li>- 654-3773-22 on the container label is expressed as 00654377322 on the claim</li> <li>- 1645-222-65 on the container label is expressed as 16457022265 on the claim</li> <li>- 12345-6-7 on the container label is expressed as 12345000607 on the claim</li> <li>- 86541-4885-77 on the container label is expressed as 86541488577 on the claim</li> </ul> <p>For multi-ingredient compounds, list each component separately, on its own claim line with the NDC and NDC quantity in this field. For more information and examples on billing outpatient facility administered drugs, see the NDC Billing Reference on the Hewlett Packard Enterprise website.</p>

*44	Situational	<b>HCPCS/Accommodation Rates/HIPPS Rate Codes:</b> Outpatient services: Enter the appropriate procedure code (HCPCS or CPT)
45	Situational	<b>Service Date:</b> REQUIRED on all outpatient claims. Enter the date of service for each service line billed (MMDDYY). Multiple dates of service may not be combined for outpatient claims
46	Required	<b>Service Units:</b> Enter the number of units, days, or visits for the service. A value of at least "1" must be entered. For inpatient room charges, enter the number of days for each accommodation listed.
47	Required	<b>Total Charges:</b> Enter the total charge for each service line.
48	Recommended	<b>Non-covered charges:</b> Enter the non-covered charges included in field 47 for the Revenue Code listed in field 42 of the service line. Do not list negative amounts.
49	Not Required	<b>Reserved for assignment by the NUBC</b>
50a-c	Line a Required Lines b&c Situational	<b>Payer Name</b> As applicable, enter the name of the recipient's primary, secondary and tertiary insurance on Lines A, B and C, respectively. On claims with no TPL, Medicaid information is entered on Line A. If the recipient has Medicare coverage (primary, secondary or tertiary), enter the word Medicare followed by the Medicare plan name
51a-c	Recommended	<b>Health Plan ID</b>
52a-c	Required	<b>Release of Information Certification Indicator (REL INFO):</b> REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter 'Y' (yes) or 'N' (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain 'Y.'
53a-c	Required	<b>Assignment of benefits certification indicator (ASG BEN):</b> Enter 'Y' (yes) or 'N' (no) to indicate a signed form is on file authorizing payment by the payer directly to the Provider for services.
54a-c	Situational	<b>Prior payments:</b> Enter the amount received from the primary payer on the appropriate line
55a-c	Line a Required Lines b&c Situational	<b>Estimated amount due</b>
56	Required	<b>National Provider Identifier - Billing Provider (NPI):</b> Enter Provider's 10- character NPI ID
57a-c	Not Required	<b>Other(Billing) Provider identifier</b>
58a-c	Required	<b>Insured's Name:</b> For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the



		patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial
59a-c	Not Required	<b>Patient's Relationship to Insured</b>
60a-c	Line a Required Lines b&c Situational	<b>Insured's unique identifier:</b> Enter the patient's Insurance ID exactly as it appears on the patient's ID card. Enter the Insurance ID in the order of liability listed in field 50.
61a-c	Recommended	<b>Insured's group name</b>
62a-c	Recommended	<b>Insured's group number</b>
63a-c	Situational	<b>Treatment authorization code</b>
64a-c	Situational	<b>Document control number:</b> Enter the original claim number of the paid/denied claim when submitting a replacement or void on the corresponding. Applies to claim submitted with a Type of Bill (field 4). Frequency of "7" (Replacement of Prior Claim) or Type of Bill. Frequency of "8" (Void/Cancel of Prior Claim).
65a-c	Not required	<b>Employer name (Of the insured)</b>
66	Not Required	<b>Diagnosis and procedure code qualifier (ICD Version Indicator)</b>
67	Required	<b>Principal Diagnosis code and Present on Admission Indicator:</b> Enter the diagnosis code for the recipient's primary condition.
67a-q	Situational	<b>Other diagnosis codes:</b> Enter a diagnosis code for each condition that coexists at the time of admission, that develops subsequently, or that affects the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode and have no bearing on the current hospital stay.
68	Not Required	<b>Reserved for assignment by the NUBC</b>
69	Situational	<b>Admitting diagnosis code:</b> Enter the diagnosis code describing the recipient's reason for admission. This is required on inpatient claims only
70a-c	Situational	<b>Patient's reason for visit:</b> Enter the ICD-9/10-CM Code that reflects the patient's reason for visit at the time of outpatient registration. Field 70a requires entry; fields 70b-70c are conditional.
71	Not Required	<b>Prospective Payment System (PPS) Code</b>
72a-c	Situational	<b>External Cause of Injury (ECI) code</b>
73	Not Required	<b>Reserved for assignment by the NUBC</b>
74	Situational	<b>Principal Procedure Code and Date:</b> Enter the ICD-9/10 Procedure Code that identifies the principal/primary procedure performed.



74a-e	Situational	<b>Other procedure codes and dates:</b> Enter diagnosis codes to identify all significant procedures (other than the principal) and the dates on which each procedure was performed. This field is required on inpatient claims when additional procedures must be reported (not required on an outpatient claim).
75	Situational	<b>Adjust or void a claim</b>
76	Recommended	<b>Attending Provider name and identifiers:</b> Enter servicing (rendering) Provider's NPI.
77	Situational	<b>Operating physician name and identifiers:</b> If a surgery was performed, enter the surgeon's NPI. In this field, Hospice, Long Term Care (Provider Type 65) claims, must enter the NPI of the nursing facility from which the recipient was transferred.
78	Situational	<b>Other:</b> Enter the NPI of the ordering, prescribing or referring Provider, if applicable.
79	Not Required	<b>Other Provider name and identifiers</b>
80	Not Required	<b>Remarks field</b>
81a-d	Situational	<b>Code-code field:</b> Use this field to report additional value codes and/or taxonomy codes if applicable.

## 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 30 calendar days from the change.

## 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 Nevada, Inc.  
 PO Box 22666  
 Long Beach, CA 90801

Please keep the following in mind when submitting paper Claims:

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

## Corrected Claim Process

Providers may correct any necessary field of the CMS 1500 and UB-04 forms. The descriptions of each field for a CMS 1500 can be found within this section.

Corrected Claims may be submitted electronically via EDI, the Provider Portal.

All corrected Claims:

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

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

Corrected Claims must be sent within the following timeframes:

- Contracted Providers: within 180 days from late of service
- Non-contracted Providers: within 365 days from date of service

## EDI (Clearinghouse) Submission of Corrected Claims

837P

- In the 2300 Loop, the CLM segment (Claim information) CLM05-3 (Claim frequency type code) must indicate one of the following qualifier codes:
  - “1”-ORIGINAL (initial Claim)
  - “7”-REPLACEMENT (replacement of prior Claim)
  - “8”-VOID (void/cancel of prior Claim)
- In the 2300 Loop, the REF \*F8 segment (Claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN).

837I

- Bill type for UB Claims are billed in loop 2300/CLM05-1. In Bill Type for UB, the “1” “7” or “8” goes in the third digit for “frequency”.

- In the 2300 Loop, the REF \*F8 segment (Claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN).

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

### COB

Medicaid is the payer of last resort. Private and governmental carriers must be billed prior to billing 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 coordination of benefits occurs, Provider shall be compensated based on the state regulatory COB methodology. Primary carrier payment information is required with the Claim submission. Providers can submit Claims with attachments, including explanation of benefits (EOB) and other required documents, by utilizing the Provider Portal. Providers can also submit this information through EDI and paper submissions.

### TPL

Molina will make all reasonable efforts to identify instances of third-party liability and exert subrogation rights to pursue recoupment of funds. Molina will contract with a TPL vendor to subrogate third-party liability cases on our behalf and will pursue settlement and recoupment when applicable in collaboration with DHCFP. Reports will be provided timely and accurately as outlined in the Medicaid Service Manual and in accordance with contractual requirements.

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 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.

## Reimbursement Guidance and Payment Guidelines

Providers are responsible for submission of accurate Claims. Molina requires coding of both diagnoses and procedures for all Claims. The required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM for diagnoses. For procedures, the Healthcare Common Procedure Coding System Level 1 (CPT codes), Level 2 and 3 (HCPCS codes) are required for professional and outpatient Claims. Inpatient hospital Claims require ICD-10-PCS (International Classification of Diseases, 10<sup>th</sup> 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 & Medicaid Services (CMS), including:
  - National Correct Coding Initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and Medically Unlikely Edits (MUE). In the event a State benefit limit is more stringent/restrictive than a Federal MUE, 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 (NCD).
  - In the absence of State guidance, Medicare Local Coverage Determinations (LCD).
  - CMS Physician Fee Schedule RVU indicators.
- Current Procedural Technology (CPT) guidance published by the American Medical Association (AMA).
- ICD-10 guidance published by the National Center for Health Statistics.
- State-specific claims reimbursement guidance.
- Other coding guidelines published by industry-recognized resources.
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than State and Federal guidelines.
- Molina policies based on the appropriateness of health care and medical necessity.
- Payment policies published by Molina.

## Telehealth Claims and Billing

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

All telehealth Claims for Molina Members must be submitted to Molina with correct codes for the plan type. The Provider at the distant site must use Place of Service (POS) Code 02 when billing for services provided via telehealth. Use of the POS code certifies the service meets telehealth requirements. Note that for distant site services billed under Critical Access Hospital (CAH) method II on institutional claims and billed by outpatient Providers on institutional claims, the GT modifier (telehealth service rendered via interactive audio and video telecommunications system) is required. Qualifying telehealth units of service for an originating site must be billed with Q3014 for reimbursement of facility fee.

## National Correct Coding Initiative (NCCI)

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

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

## 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. 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-Ketotic Hyperosmolar Coma
  - d) Secondary Diabetes with Ketoacidosis

- e) Secondary Diabetes with Hyperosmolarity
- 7) Catheter-Associated Urinary Tract Infection (UTI)
- 8) Vascular Catheter-Associated Infection
- 9) Surgical Site Infection Following Coronary Artery Bypass Graft – Mediastinitis
- 10) Surgical Site Infection Following Certain Orthopedic Procedures:
  - a) Spine
  - b) Neck
  - c) Shoulder
  - d) Elbow
- 11) Surgical Site Infection Following Bariatric Surgery Procedures for Obesity
  - a) Laparoscopic Gastric Restrictive Surgery
  - b) Laparoscopic Gastric Bypass
  - c) Gastroenterostomy
- 12) Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)
- 13) Iatrogenic Pneumothorax with Venous Catheterization
- 14) Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
  - a) Total Knee Replacement
  - b) Hip Replacement

What this means to Providers

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

If you would like to find out more information regarding the Medicare HAC/POA program, including billing requirements, the following CMS site provides further information: [cms.hhs.gov/HospitalAcqCond/](https://cms.hhs.gov/HospitalAcqCond/)

## 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 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, 10<sup>th</sup> Revision, Clinical Modification (ICD-10-CM) and International Classification of Diseases 10<sup>th</sup> 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) 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.

## National Drug Code (NDC)

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

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

## Coding Sources

### Definitions

CPT – Current Procedural Terminology 4th Edition; an American Medical Association (AMA) maintained uniform coding system consisting of descriptive terms and codes that 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, 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 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.

## 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 30 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](https://www.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.

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 Appeals/Disputes

A Provider Dispute is defined as both grievances and appeals.

An appeal is a request to review an action as an “action”. The appeal process addresses payment disputes and instances when the Plan chooses to deny, reduce, suspend or terminate a Provider’s privileges with the Plan. The appeal process also includes challenging the Plan’s request for reimbursement for an overpayment of a claim.

A grievance is an expression of dissatisfaction with any aspect of the Medicaid managed care health plan’s operations, activities or behavior, regardless of whether the communication requests any remedial actions.

Providers appealing a Claim previously adjudicated must request such action within 30 calendar days from the last date of determination or action. All Claim appeals must be submitted on the Provider Dispute Resolution Request Form or a Letter of Explanation.

The Provider Dispute Resolution Request Form found on Provider website and the Provider Portal. The form must be filled out completely in order to be processed. The Letter of Explanation must include all elements on the Provider Dispute Resolution Request Form such as the Provider name, identification number, and contact information, date of service, claim number, explanation of the appeal, and all required documentation or proof to support the appeal. Appeals with incomplete information or missing required documents will not be processed. Molina allows two resubmissions of a claim appeal.

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

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

#### **How to Submit Provider Appeals:**

- Availability Provider Portal: [Provider.MolinaHealthcare.com](http://Provider.MolinaHealthcare.com)
- Submitted via fax: (833) 412-3146
- Mail: U.S. Mail at the following address:

Molina Healthcare of Nevada, Inc.  
Attention: Provider Dispute Resolution Unit  
PO Box 401825  
Las Vegas, NV 89140

**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 calendar days of receipt of the Claims Appeal request.

#### **State Fair Hearing:**

Providers seeking further recourse and have exhausted the Plan's internal appeals process, have the right to submit a written request to the State for a State Fair Hearing.

Disputes eligible for the State Fair Hearing process include:

- Denial or limited authorization of a requested service
- Reduction, suspension or termination of a previously authorized service
- Denial, in whole or part, of payment for a service
- Demand for recoupment
- Failure of the Plan to meet specified timeframes (e.g., authorization, claims processing, appeal resolution)

The request for a State Fair Hearing must be submitted in writing within 90 calendar days from the date of Molina's resolution of the appeal.

Nevada Division of Medicaid  
Nevada Medicaid Hearings Unit  
1100 East William Street-Suite 101  
Carson City, NV 89701

Fax # (775) 684-3610

E-mail: <mailto:dhcfphearings@dhcfp.nv.gov>

## Balance Billing

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

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Molina to the Provider. Balance billing a Molina Member for Covered Services is prohibited, other than for the Member's applicable copayment, coinsurance and deductible amounts.

## Fraud and Abuse

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

## Encounter Data

Each Provider, capitated Provider or organization delegated for Claims processing is required to submit Encounter data to 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 bi-weekly, and within 60 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 of Supporting all 837 file formats and proprietary formats if needed.

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

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

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

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

## 13. GRIEVANCE AND APPEALS PROCESS

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If a Member is unhappy with anything about Molina Healthcare or its Providers, the Member should contact us as soon as possible. This includes if the Member does not agree with a decision we have made. The Member, or someone on the Member's behalf, can contact us. If the Member wants someone to speak for them, they will need to let us know this. Molina can help the Member with this process by calling Member Services.

These services are free of charge. Members can call us at (844) 685-2102, TTY/TDD 711 Monday to Friday from 8 a.m. to 6 p.m. (PT). A translator is available if a Member needs to speak in their own language and can help file their complaint, grievance, or appeal request. This service is free to all of our Members.

### Definitions

**Grievance:** Any oral or written communications made by a Member, or a Provider acting on behalf of the Member with the Member's written consent, to Molina expressing dissatisfaction or making a complaint with any aspect of the Molina's or Provider's operations, activities, or behavior, regardless of whether the communication requests any remedial actions.

**Appeal:** An appeal is a Member (or Member's representative) specific request for review of an adverse benefit determination.

**Provider Dispute:** Provider Disputes encompass both grievances and appeals made by Providers. An appeal is a request to review an "action". A grievance is an expression of dissatisfaction with any aspect of Molina's operations, activities or behavioral, regardless of whether the communication requests any remedial actions.

### Member Grievance Process and Timelines.

Member Grievances may be filed orally or in writing. Grievances may be filed at any time. Molina will send an acknowledgement letter within 5 calendar days from the date of receipt as acknowledgement of receipt of the grievance. Molina's investigation and final resolution will be completed within 90 calendar days (with a possible 14 calendar day extension). A Member has the right to file a grievance if the Member disagrees with the decision to extend the timeframe.

Molina will not take any punitive actions against any provider who represents a Member with regard to a filed Grievance.

Grievances may be submitted via the following methods:

Email: [NV\\_Member\\_Grievance@MolinaHealthCare.com](mailto:NV_Member_Grievance@MolinaHealthCare.com)

Fax: (833) 412-3137

Phone: (833) 685-2102

Mail:

Molina Healthcare of Nevada  
Attention Member Appeals and Grievances  
PO Box 401820  
Las Vegas, NV 89140

## Member Appeals Process and Timelines

Appeals may be submitted orally or in writing by Member, a Provider acting on behalf of the Member, or a Member's representative. In the event a Provider files an Appeal on the Member's behalf, the Provider must first obtain the Member's written permission with the exception of an expedited appeal. Molina will send an acknowledgement letter in 24 hours for Expedited Appeals and five calendar days for Standard Appeals from the date of receipt as acknowledgement of receipt of the appeal. Appeals must be submitted within 60 calendar days from the date on the notice of determination.

Molina will not take any punitive actions against any provider who represents a Member with regard to a filed Appeal.

Member Appeals may be submitted via the following methods:

Email: [NV\\_Member\\_Appeals@MolinaHealthCare.com](mailto:NV_Member_Appeals@MolinaHealthCare.com)  
Fax: (833) 412-3145  
Phone: (833) 685-2102  
Mail:

Molina Healthcare of Nevada  
Attention Member Appeals and Grievances  
PO Box 401820  
Las Vegas, NV 89140

## Expedited Appeals

A Molina Member, Provider acting on behalf of the Member, or Member's representative, may file an expedited appeal within 60 calendar days from the date on the notice of determination. Molina reviews the appeal, and a final determination will be made within 72 hours (with a possible 14 calendar day extension) of receiving all required information for appeals meeting the definition urgent/expedited. If the Plan denies a request for an expedited resolution of an Appeal, it will transfer the Appeal to the standard timeframe of no longer than 30 calendar days from the day the Plan receives the Appeal (with a possible 14 calendar day extension) for resolution of Appeal and give the Member prompt oral notice of the denial and follow up within two Calendar days with a written notice. Members have the right to file a Grievance if the Member disagrees with the decision to extend the timeframe.

## Standard Appeals Process and Timeline

A Molina Member, Provider acting on behalf of the Member, or Member's representative, may file a standard appeal within 60 calendar days from the date on the notice of determination.

Molina reviews Member appeals and provides a final determination within 30 calendar days (with a possible 14 calendar day extension) of receiving all required information. Members have the right to file a Grievance if the Member disagrees with the decision to extend the timeframe.

### **Continuing the Member's Benefits During the Appeal or State Fair Hearing Process:**

Molina will continue the member's benefits while the Plan's internal Appeals process is pending and while the State Fair Hearing is pending if all of the following conditions exist:

- The member's request for continuation of benefits is submitted to the Plan on or before the later of the following:
  - within ten (10) Calendar Days of the Plan mailing the Notice of Adverse Benefit Determination; or, the intended effective date of the Plan's proposed Adverse Benefit Determination;
- The member file the request for an Appeal within sixty (60) Calendar days following the date on the Adverse Benefit Determination notice;
- The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized Provider;
- The original periods covered by the original authorization have not expired; and
- The member requests an extension of benefits timely.

The member may have to pay for those services if the denial is upheld.

Molina will provide benefits until one (1) of the following occurs:

- The member withdraws the appeal;
- Ten (10) calendar days have passed from the date of the notice of appeal resolution and the member have not asked for a State Fair Hearing;
- The State Fair Hearing Officer makes a State Fair Hearing decision not in the member's favor.

To ask for continuation of benefits during the Appeal process, the member may call us or can send their request in writing to:

Molina Healthcare of Nevada



Attention: Appeals & Grievances Department  
PO Box 401820  
Las Vegas, NV 89140

If the final Appeal decision is not in the member's favor, the member may have to pay for the services they were getting while the appeal was being reviewed. If the final appeal decision is in the member's favor and the services were not given to the member while the appeal was being looked at, Molina will authorize the services for the member as quickly as their health requires, but no later than seventy-two (72) hours from the date of the approval.

Molina will ensure that punitive action is not taken against any provider who requests an expedited resolution or supports an appeal.

### State Fair Hearing

A Member may request a State Fair Hearing if the Molina's appeal system has been exhausted, and the final decision was not wholly in the Member's favor. The request for a State Fair Hearing must be submitted in writing within 90 calendar days from the date of Molina's resolution of the appeal.

Nevada Medicaid Hearings Unit  
1100 East William Street-Suite 101  
Carson City, NV 89701

Fax: (775) 684-3610

E-mail: [dhcfphearings@dhcfp.nv.gov](mailto:dhcfphearings@dhcfp.nv.gov)

### Provider Disputes

#### Provider Grievances

Providers may file grievances at any time. Molina will investigate and provide final resolution within 90 calendar days. Providers may file grievances via the following methods:

Phone: (833) 685-2103

Fax: (833) 412-3146

Secure email: [NV\\_Provider\\_AG@MolinaHealthCare.Com](mailto:NV_Provider_AG@MolinaHealthCare.Com)

Mail:

Molina Healthcare of Nevada  
Attention Member Appeals and Grievances  
PO Box 401825  
Las Vegas, NV 89140

## Claim Appeals/Disputes

For information on the Claim Appeals/Disputes process, please see the Claims Appeals/Disputes sub-section within the Claims and Compensation chapter of this manual.

Molina will not take any punitive actions against any provider who files a Grievance or Claims Appeal/Dispute.

## 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.

## Record Retention

The plan will retain records of all Provider Disputes for a minimum of 10 years and will review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to DHCFP's quality strategy.

The record of each dispute will contain, at a minimum, all of the following information:

- A general description of the reason for the dispute.
- The date received.
- The date of each review or, if applicable, review meeting.
- Resolution at each level of the dispute, if applicable.
- Name of the covered person for whom the dispute was filed.

The record will be accurately maintained in a manner accessible to DHCFP and available upon request to CMS.

## 14. NETWORK DEVELOPMENT, CREDENTIALING AND RE-CREDENTIALING

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### Network Development and Maintenance

Molina Healthcare maintains a network of qualified Providers in sufficient numbers and locations that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its Members, both adults and children, without excessive travel requirements, and that is in compliance with DHCFP's access and availability requirements. All Providers who provide services to Molina Members agree to comply with all federal and state laws.

Molina Healthcare offers a network of primary care Providers to ensure every Member has access to a Medical Home within the required travel distance standards.

To ensure Molina Members continue to have access to quality care and ensure compliance, Molina will conduct a review of our Provider network on a weekly basis.

In the event of a network gap in services, Molina will make best efforts to remedy the gap through contracting efforts. In the event that a Provider is unavailable to fill the gap, Molina will notify the state in accordance with regulatory standards.

In addition, Molina will have available, at a minimum, the following Provider types:

- Hospital, Outpatient Surgery
- Hospital, Inpatient
- Hospital, Outpatient
- Psychiatric Hospital, Inpatient
- Behavioral Health Outpatient Treatment
- Intermediate Care Facility/MR (Public)
- Special Clinics
- Nursing Facility
- Physician, MD/Osteopath DO
- Podiatrist
- Dentist
- Hearing Aid Dispenser & Related Supplies
- Advanced Practice Registered Nurse (APRN)
- Optometrist
- Psychologist
- Radiology & Noninvasive Diagnostic Centers
- Pharmacy
- Home Health Agency
- Personal Care Aide (Home Care)
- Ambulance – Air or Ground
- Durable Medicaid Equipment (DME), Disposables, Prosthetics
- Therapy – Physical, Occupational, Respiratory, Speech

- Chiropractor
- Intravenous Therapy (TPN)
- Home and Community Based Waiver – Individuals with Intellectual Disabilities and Related Conditions
- Adult Day Health Care
- Optician/Optical Businesses
- Laboratory – Pathology/Clinical
- Swing-bed (Acute Hospitals)
- End Stage Renal Disease (ERSD) ESRD Facility
- Ambulatory Surgery Centers (Medicare Certified) Free-Standing
- Indian Health Programs
- Home and Community Based Waiver for the Frail Elderly
- IHS/Tribal Hospital (Inpatient)
- IHS/Tribal Hospital (Outpatient)
- Targeted Case Management
- Home Based Habilitation Services
- Medical (Rehabilitation and Long-Term Acute Care (LTAC) Specialty Hospitals
- Elderly in Adult Residential Care Waiver
- Physically Disabled Waiver
- Home and Community Based Assisted Living Waiver – Augmented Personal Care Services
- School Based Services
- Residential Treatment Center (RTC)
- Hospice Services
- Hospice Long Term Care
- Intermediate Care Facility/ IID (Private)
- Nurse Anesthetist
- Nurse Midwife
- Critical Access Hospital (CAH), Inpatient
- Audiologist
- Physician's Assistant
- Indian Health Services – Inpatient (non-tribal)
- Indian Health Services – Outpatient (non-tribal)
- ESRD
- Behavioral Health Rehabilitation Treatment
- Personal Care Aide (PCA) - Intermediary Services Organization
- Applied Behavior Analysis

Molina Healthcare will also use Community Mental Health Centers (CMHCs) to cover Mental Illness Rehabilitative services as required.

In the event Molina's network is unable to provide medically necessary services required under the contract, Molina shall ensure timely and adequate coverage of these services through an out of network Provider until a network Provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances.

For assistance in making a referral to a specialist or subspecialties for a Molina Member, please contact our (833) 685-2103 and we will identify a Provider to make the necessary referral.

We do not limit the participation of any Provider or facility in the network, and/or otherwise discriminate against any Provider or facility based solely on any characteristic protected under state or federal discrimination laws. We also do not discriminate for reimbursement or indemnification of any Provider who is acting within the scope of their license or certification under applicable state law, solely on the basis of that license or certification. If Molina Healthcare declines to include individual or groups of Providers in our network, we will give the affected Providers written notice of the reason for the decision.

Furthermore, Molina does not have, and has never had, a policy of terminating any Provider who:

- Advocated on behalf of a Member
- Filed a complaint against Molina
- Appealed a decision made by Molina

Molina Healthcare offers a network of tertiary care inclusive of trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities and medical sub specialists available 24-hours per day in the geographical service area. In the event Molina's network is unable to provide the necessary tertiary care services required, Molina shall ensure timely and adequate coverage of these services through an out of network Provider until a network Provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances.

## Credentialing

The purpose of the Credentialing Program is to assure the Molina Healthcare and its subsidiaries (Molina) network consists of quality Providers who meet clearly defined criteria and standards. It is the objective of Molina to provide superior health care to the community. Additional information is available in the Credentialing Policy and Procedure which can be requested by contacting your Molina Provider Services representative.

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

The Credentialing Program has been developed in accordance with State and Federal requirements and the standards of the National Committee for Quality Assurance (NCQA). The Credentialing Program is reviewed annually, revised, and updated as needed.

## Non-Discriminatory Credentialing and Recredentialing

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

## Types of Practitioners Credentialed & Recredentialed

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

- Acupuncturists
- Addiction medicine specialists
- Audiologists
- Behavioral health care practitioners who are licensed, certified or registered by the State to practice independently
- Chiropractors
- Clinical Social Workers
- Dentists
- Doctoral or 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

## Criteria for Participation in the Molina Network

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

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

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

- **Application** – Provider must submit to Molina a complete credentialing application either from CAQH ProView or other State mandated practitioner application. The attestation must be signed within 120 days. Application must include all required attachments.
- **License, Certification or Registration** – Provider must hold a current and valid license, certification or registration to practice in their specialty in every State in which they will provide care and/or render services for Molina Members. Telemedicine Practitioners are required to be licensed in the State where they are located, and the State the Member is located.
- **Medicaid enrollment**—Provider must be enrolled with the State as a Medicaid Provider. Prior to becoming a network Provider, a Provider who is a non-Medicaid enrolled Provider will be referred to the State's fiscal agent and must complete the Medicaid Provider enrollment process. The Provider is not required to see FFS recipients.
- **DEA or CDS Certificate** – Provider must hold a current, valid, unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Provider must have a DEA or CDS in every State where the Provider provides care to Molina Members. If a Practitioner has never had any disciplinary action taken related to their DEA and/or CDS and has a pending DEA/CDS certificate or chooses not to have a DEA and/or CDS certificate, the Practitioner



must then provide a documented process that allows another Practitioner with a valid DEA and/or CDS certificate to write all prescriptions requiring a DEA number.

- **Specialty** – Providers will only be credentialed in the specialty in which they have adequate education and training. Providers must confine their practice to their credentialed area of practice when providing services to Molina Members.
- **Education** – Provider must have graduated from an accredited school with a degree required to practice in their designated specialty.
- **Residency Training** – Provider must have satisfactorily completed a residency program from an accredited training program in the specialty in which they are practicing. Molina only recognizes residency training programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA). Training must be successfully completed prior to completing the verification. It is not acceptable to verify completion prior to graduation from the program. As of July 2013, podiatric residencies are required to be three years in length. If the podiatrist has not completed a three-year residency or is not board certified, the podiatrist must have five years of work history practicing podiatry.
- **Fellowship Training** – If the Provider is not board certified in the specialty in which they practice and has not completed a residency program in the specialty in which they practice, they must have completed a fellowship program from an accredited training program in the specialty in which they are practicing.
- **Board Certification** – Board certification in the specialty in which the Practitioner is practicing is not required. Initial applicants who are not board certified will be considered for participation if they have satisfactorily completed a residency program from an accredited training program in the specialty in which they are practicing. Molina recognizes board certification only from the following Boards:
  - American Board of Medical Specialties (ABMS)
  - American Osteopathic Association (AOA)
  - American Board of Foot and Ankle Surgery (ABFAS)
  - American Board of Podiatric Medicine (ABPM)
  - American Board of Oral and Maxillofacial Surgery
  - American Board of Addiction Medicine (ABAM)
  - College of Family Physicians of Canada (CFPC)
  - Royal College of Physicians and Surgeons of Canada (RCPSC)
  - Behavioral Analyst Certification Board (BACB)
  - National Commission on Certification of Physician Assistants (NCCPA)
- **General Practitioners** – Practitioners who are not board certified and have not completed a training program from an accredited training program are only eligible to be considered for participation as a General Practitioner in the Molina network. To be eligible, the Practitioner must have maintained a primary care



practice in good standing for a minimum of the most recent five years without any gaps in work history. Molina will consider allowing a Practitioner who is/was board certified and/or residency trained in a specialty other than primary care to participate as a General Practitioner, if the Practitioner is applying to participate as a Primary Care Physician (PCP), Urgent Care or Wound Care. General Practitioners providing only wound care services do not require five years of work history as a PCP.

- **Nurse Practitioners & Physician Assistants** – In certain circumstances, Molina may credential a Practitioner who is not licensed to practice independently. In these instances, it would also be required that the Practitioner providing the supervision and/or oversight be contracted and credentialed with Molina.
- **Work History** – Provider must supply most recent five-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds six months, the Practitioner must clarify the gap verbally or in writing. The organization documents a verbal clarification in the Practitioner's credentialing file. If the gap in employment exceeds one year, the Practitioner must clarify the gap in writing.
- **Malpractice History** – Provider must supply a history of malpractice and professional liability claims and settlement history in accordance with the application.
- **Professional Liability Insurance** – Provider must supply a history of malpractice and professional liability claims and settlement history in accordance with the application. Documentation of malpractice and professional liability claims, and settlement history is requested from the Practitioner on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **State Sanctions, Restrictions on Licensure or Limitations on Scope of Practice** – Practitioner must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations and non-renewals. Practitioner must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing, or failure to proceed with an application in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Molina will also verify all licenses, certifications and registrations in every State where the Practitioner has practiced. At the time of initial application, the practitioner must not have any pending or open investigations from any State or governmental professional disciplinary body<sup>3</sup>. This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.

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<sup>3</sup> If a practitioner's application is denied solely because a practitioner has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state Molina Healthcare of Nevada, Inc. Medicaid and Nevada Check Up Provider Manual. 127  
Any reference to Molina Members means Molina Healthcare Medicaid/Nevada Check Up Members.

- **Medicare, Medicaid and other Sanctions and Exclusions** – Practitioner must not be currently sanctioned, excluded, expelled or suspended from any State or Federally funded program including but not limited to the Medicare or Medicaid programs. Practitioner must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner. Practitioner must disclose all debarments, suspensions, proposals for debarments, exclusions or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Medicare Opt Out** – Practitioners currently listed on the Medicare Opt-Out Report may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Social Security Administration Death Master File** – Practitioners must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File.
- **Medicare Preclusion List** – Practitioners currently listed on the Preclusion List may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Professional Liability Insurance** – Practitioner must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina Members and the practitioner’s activities on Molina's behalf. Practitioners maintaining coverage under a Federal tort or self-insured are not required to include amounts of coverage on their application for professional or medical malpractice insurance.
- **Inability to Perform** – Practitioner must disclose any inability to perform essential functions of a practitioner in their area of practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Lack of Present Illegal Drug Use** – Practitioner must disclose if they are currently using any illegal drugs/substances.
- **Criminal Convictions** – Practitioner must disclose if they have ever had any criminal convictions. Practitioner must never have been convicted, including guilty pleas and adjudicated pretrial diversions for crimes against person such as murder, rape, assault and other similar crimes. Financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud and other similar

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or governmental professional disciplinary body, the practitioner may reapply as soon as practitioner is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action, or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one year from the date of original denial.

crimes. Any crime that placed the Medicaid or Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct. Any crime that would result in mandatory exclusion under section 1128 of the Social Security Act. Any crime related to fraud, kickbacks, healthcare fraud, claims for excessive charges, unnecessary services or services which fail to meet professionally recognized standards of healthcare, patient abuse or neglect, controlled substances, or similar crimes. At the time of initial credentialing, practitioner must not have any pending criminal charges in the categories listed above.

- **Loss or Limitations of Clinical Privileges** – At initial credentialing, practitioner must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner. At recredentialing, practitioner must disclose past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the practitioner has had privileges since the previous credentialing cycle.
- **Hospital Privileges** – Practitioners must list all current hospital privileges on their credentialing application. If the practitioner has current privileges, they must be in good standing.
- **NPI** – Practitioner must have a National Provider Identifier (NPI) issued by the Centers for Medicare & Medicaid Services (CMS).

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

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

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

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

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

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

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

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

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

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

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

## **Practitioner's Right to be Informed of Application Status**

Practitioners have a right, upon request, to be informed of the status of their application by telephone, email or mail. Practitioner's rights are published on the Molina website and are included in this Provider Manual. Molina will respond to the request within two (2) working days. Molina will share with the practitioner where the application is in the credentialing process to include any missing information or information not yet verified.

## **Notification of Credentialing Decisions**

A letter is sent to every Provider with notification of the Professional Review Committee or Medical Director decision regarding their participation in the Molina network. This notification is sent within forty-five (45) calendar days of receipt of a Provider's request for credentialing or a Provider's completed uniform credentialing form, whichever is earlier. This will allow for time to obtain the credentialing form in electronic format, request and obtain third party verification, and make and notify the Provider of the

decision. The forty-five (45) day period will not commence until the applicant provides all requested information or documentation. Copies of the letters are filed in the Provider's credentials files.

## Recredentialing

Molina recredentials every Practitioner at least every thirty-six (36) months.

Molina will notify the Provider at least one-hundred-twenty (120) days in advance of all items necessary to complete recredentialing. Molina will complete the recredentialing process within forty-five (45) days of receipt of the Provider's complete recredentialing application and all supporting documents.

In general, once a credentialing application has been approved, re-credentialing verification may not be required more frequently than every three (3) years. If Molina has approved an application provisionally, then re-credentialing may be required annually or at the conclusion of a shorter period if required by Molina's accreditation organization and approved by OSI. Nothing in this section shall be construed to require Molina to credential or provisionally credential any Provider. Nothing in this section shall be construed to prevent Molina from terminating its participation agreement with a Provider for cause at any time; regardless of time remaining before re-credentialing is due.

Except as may otherwise be required by Molina's accreditation organization, Molina may not require a participating Provider to be re-credentialed based on: (a) a change in the Provider's Federal Tax Identification number; (b) a change in the Federal Tax Identification number of a Provider's employer; or (c) a change in the Provider's employer, if the new employer: (i) is a participating Provider; or (ii) also employs other participating Providers. Molina may require a participating Provider or the Provider's employer to give written notice of a change in the Provider's or the Provider's employer's Federal Tax Identification number not less than forty-five (45) calendar days before the effective date of the change.

## Excluded Providers

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

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

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

## Ongoing Monitoring of Sanctions and Exclusions

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

- The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program – Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs.
- State Medicaid Exclusions – Monitor for State Medicaid exclusions through each state's specific Program Integrity Unit (or equivalent).
- Medicare Exclusion Database (MED) – Molina monitors for Medicare exclusions through the Centers for Medicare & Medicaid Services (CMS) MED online application site.
- Medicare Preclusion List – Monitor for individuals and entities that are reported on the Medicare Preclusion List.
- National Practitioner Database – Molina enrolls all credentialed practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles.
- System for Award Management (SAM) – Monitor for Providers sanctioned with SAM.

Molina also monitors the following for all Provider types between the recredentialing cycles.

- Member Complaints/Grievances
- Adverse Events
- Medicare Opt Out
- Social Security Administration Death Master File

## Provider Appeal Rights

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



## 15. DELEGATION

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

1. Medical Management
2. Credentialing and Recredentialing
3. Sanction Monitoring for employees and contracted staff at all levels
4. Claims
5. Complex Case Management
6. CMS Preclusion List Monitoring
7. Other Clinical and Administrative Functions

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

### Delegation Reporting Requirements

Delegated entities contracted with Molina must submit monthly and quarterly reports. Such reports will be determined by the function(s) delegated and will be reviewed by Molina Delegation Oversight Staff within the timeline indicated by Molina.

### Corrective Action Plans and Revocation of Delegated Activities

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

If you have additional questions related to delegated functions, please contact your Molina Contract Manager.

## 16. PHARMACY

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

### Pharmacy and Therapeutics Committee

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

### Pharmacy Lock-In Program

The Pharmacy Lock-In Program is designed to address the unique needs of those Members who have demonstrated:

- Fraudulent or abusive patterns of service utilization; or
- Behavior that may indicate a chemical dependency issue; or
- Prescription and/or service over-utilization that may represent a danger to the Member.

A multidisciplinary care team including physicians, pharmacists, registered nurses, licensed social workers and other allied health professionals comprise the team and have primary responsibility for the administration and oversight of the program.

Members exhibiting potential/suspected over-utilization of narcotic analgesics and/or other controlled substance medication(s) are identified by Molina Healthcare staff, by claims data analysis and/or by a referral from the Member's primary care Provider. Once identified, final Member enrollment into the Lock-In Program will be determined by Medical Director, Pharmacist, and/or Care Coordinator review.

Members suitable for Lock In will receive the following:

- A case manager will initiate Care Management efforts
- Program enrollment notification, including a program brochure and Provider/Pharmacy Selection Form.

Members will remain in the program for up to three years on the initial Lock-in assignment. Re-evaluation will be done after the initial 3 years Lock-in to determine



whether Members will remain or may be removed from Lock-in status. The Member will be notified of the outcome.

## Pharmacy Network

Members must use their Molina ID card to get prescriptions filled. Additional information regarding the pharmacy benefits, limitations, and network pharmacies is available by visiting [MolinaHealthcare.com](https://www.molinahealthcare.com) or calling Molina at (833) 685-2103.

## Drug Formulary

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

Information on procedures to obtain these medications is described within this document and also available on the Molina website at [MolinaHealthcare.com](https://www.molinahealthcare.com).

## Formulary Medications

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

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

## Quantity Limitations

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

## Age Limits

Some medications may have age limits. Age limits align with current U.S. Food and Drug Administration (FDA) alerts for the appropriate use of pharmaceuticals.

## Step Therapy

Plan restrictions for certain Formulary drugs may require that other drugs be tried first. The Formulary designates drugs that may process under the pharmacy benefit without prior authorization if the Member's pharmacy fill history with Molina shows other drugs have been tried for certain lengths of time. If the Member has trialed certain drugs prior to joining Molina, documentation in the clinical record can serve to satisfy requirements when submitted to Molina for review. Drug samples from Providers or manufacturers

are not considered as meeting step therapy requirements or as justification for exception requests.

## Non-Formulary Medications

Non-formulary medications may be considered for exception when formulary medications are not appropriate for a particular Member or have proven ineffective. Requests for formulary exceptions should be submitted using a PA form [MolinaHealthcare.com/providers/nv/medicaid/resources/forms.aspx](https://MolinaHealthcare.com/providers/nv/medicaid/resources/forms.aspx) . Clinical evidence must be provided and is taken into account when evaluating the request to determine medical necessity. The use of manufacturer's samples of Non-Formulary or "Prior Authorization Required" medications does not override Formulary requirements.

## Generic Substitution

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

## New to Market Drugs

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

## Medications Not Covered

Medications not covered by Medicaid/Nevada Check Up (as applicable) are excluded from coverage. For example, drugs used in the treatment of fertility or those used for cosmetic purposes are not part of the benefit.

## Submitting a Prior Authorization Request

Molina will only process completed PA request forms [MolinaHealthcare.com/providers/nv/medicaid/resources/forms.aspx](https://MolinaHealthcare.com/providers/nv/medicaid/resources/forms.aspx), the following information MUST be included for the request form to be considered complete:

- Member first name, last Name, date of birth and identification number.
- Prescriber first name, last name, NPI, phone number and fax number.
- Drug name, strength, quantity and directions of use.
- Diagnosis.

Molina's decisions are based upon the information included with the PA request. Clinical notes are recommended. If clinical information and/or medical justification is missing Molina will either fax or call your office to request clinical information be sent in to complete the review. To avoid delays in decisions, be sure to complete the PA form in its entirety, including medical justification and/or supporting clinical notes.

Fax a completed Medication PA Request form to Molina at (844) 259-1689. A blank Medication PA Request Form may be obtained by accessing [MolinaHealthcare.com](https://www.molinahealthcare.com) or by calling (833) 685-2103.

## **Member and Provider “Patient Safety Notifications”**

Molina has a process to notify Members and Providers regarding a variety of safety issues which include voluntary recalls, FDA required recalls and drug withdrawals for patient safety reasons. This is also a requirement as an NCQA accredited organization.

## **Specialty Pharmaceuticals, Injectable and Infusion Services**

Many specialty medications are covered by Molina through the pharmacy benefit using National Drug Codes (NDC) for billing and specialty pharmacy for dispensing to the Member or Provider. Some of these same medications maybe covered through the medical benefit using Healthcare Common Procedure Coding System (HCPCS) and NDC via paper or electronic medical Claim submission.

Molina, during the utilization management review process, will review the requested medication for the most cost-effective, yet clinically appropriate benefit (medical or pharmacy) of select specialty medications. All reviewers will first identify Member eligibility, any Federal or State regulatory requirements, and the Member specific benefit plan coverage prior to determination of benefit processing.

If it is determined to be a pharmacy benefit, Molina’s specialty pharmacy vendor will coordinate with Molina and ship the prescription directly to your office or the Member’s home. All packages are individually marked for each Member, and refrigerated drugs are shipped in insulated packages with frozen gel packs. The service also offers the additional convenience of enclosing needed ancillary supplies (needles, syringes and alcohol swabs) with each prescription at no charge. Please contact your Provider Relations representative with any further questions about the program.

Newly FDA approved medications are considered non-formulary and subject to non-formulary policies and other non-formulary utilization criteria until a coverage decision is rendered by the Molina Pharmacy and Therapeutics Committee. “Buy-and-bill” drugs are pharmaceuticals which a Provider purchases and administers, and for which the Provider submits a claim to Molina for reimbursement.

## **Pain Safety Initiative (PSI) Resources**

Safe and appropriate opioid prescribing and utilization is a priority for all of us in health care. Molina requires Providers to adhere to Molina’s drug formularies and prescription policies designed to prevent abuse or misuse of high-risk chronic pain medication. Providers are expected to offer additional education and support to Members regarding Opioid and pain safety as needed.

Molina is dedicated to ensuring Providers are equipped with additional resources, which can be found on the Molina Provider website. Providers may access additional Opioid-safety and Substance Use Disorder resources at [MolinaHealthcare.com](https://MolinaHealthcare.com) under the Health Resource tab. Please consult with your Provider Services representative or reference the medication formulary for more information on Molina's Pain Safety Initiatives.