PROVIDER MANUAL
(Provider Handbook)

Molina Healthcare of Nevada, Inc.
(Molina Healthcare or Molina)

Nevada Medicaid and Nevada Check Up 2025

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

Last Updated: 6/2025

MOLINA HEALTHCARE

Contents

1. Contact information

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

Provider Services

The Molina Provider Contact Center handles telephone inquiries from Providers regarding claims, appeals, authorizations, eligibility, and general concerns. Molina Provider Contact Center representatives are available 8 a.m. to 6 p.m. excluding state and federal holidays.

Molina strongly encourages Participating Providers to submit Claims electronically via a clearinghouse or the Availity Essentials (Availity) portal whenever possible.
EDI Payer ID Number: MLNNV

To verify the status of your Claims please use the Availity portal. Claim questions can be submitted through the Secure Messaging feature via the Claim Status module on the Availity portal, or by contacting the <Molina> Provider Contact Center.

Eligibility verifications can be conducted at your convenience via the Eligibility and Benefits module on the Availity Essentials Portal.
Phone: (833) 685-2103
Availity portal: provider.molinahealthcare.com
Hearing Impaired (TTY/TDD): 711

Provider relations

The Provider Relations department manages Provider calls regarding issue resolution, Provider education and training. The department has Provider Relations representatives who serve all of Molina's Provider network.

You may contact NVProviderRelations@molinahealthcare.com

Contracting inquiries: NVProviderContracting@molinahealthcare.com

Member Services

The Member Services department handles all telephone inquiries regarding benefits, eligibility/ identification, Pharmacy inquiries, selecting or changing Primary Care Providers (PCPs), and Member complaints, offers to assist Members with obtaining Medicaid-covered services, and offers to assist Members with filing grievances.

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.

Phone (833) 685-2102

Hearing Impaired TTY/TDD: 711

Claims

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

- Access the Availity portal
- EDI Payer ID: MLNNV

To verify the status of Claims, please use the Availity portal. Claim questions can be submitted through the Secure Messaging feature via the Claim Status module on the Availity portal or by contacting the <Molina> Provider Contact Center. For additional information please refer to the **Claims and Compensation** section of this Provider Manual.

Phone: (833) 685-2103

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

Claims Recovery

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

Provider Disputes	Molina Healthcare of Nevada PO Box 2470 Spokane, WA 99210-2470
Refund Checks Lockbox	Molina Healthcare of Nevada PO BOX 561582 Denver, CO 80256-1582
Phone	(866) 642-8999
Fax	(702) 866-9724

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 additional information on fraud, waste, and abuse, please refer to Compliance section of this Provider Manual.

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

Phone: (866) 606-3889

Online: 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. For additional information about Molina's Credentialing program, including Policies and Procedures, please refer to the Credentialing and Recredentialing section of this Provider Manual.

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

Phone: (833) 685-2104

TTY/TDD: 711 Relay

Healthcare services

The Healthcare Services 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 costs 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 portal
- Submit requests via 278 transactions See the EDI tab of Molina's Provider website for guidance
  Availity portal
  Phone: (833) 685-2103
  PA Fax: (775) 460-4900

Health Management

Molina provides Health Management Programs designed to assist members and their families in better understanding their chronic health condition(s) and adopting healthy lifestyle behaviors. The programs include:

- Molina My Health – Tobacco Cessation Program
- Molina My Health – Weight Management Program
- Molina My Health – Nutrition Consult Program
  Phone: (833) 269-7830

  Fax: (800) 642-3691

  Email: MHIHealthEducationMailbox@MolinaHealthcare.com

Behavioral health

Molina manages all components of covered services for behavioral health. For general Member behavioral health needs, please contact us directly at (833) 685-2102. Molina has a nurse advice crisis line that Members may access 24 hours per day, 365 days per year by calling (833) 685-2104. The Nurse advice line will triage calls to the appropriate staff. For additional information please refer to the **Behavioral Services** section of this Provider Manual.

Pharmacy

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

Phone: (833) 685-2103

Pharmacy PA Fax: (844) 259-1689

For additional information please refer to the **Pharmacy** section of this Provider Manual

In Lieu of Services (ILOS)

In Lieu of Services (ILOS) are services or settings that Medicaid plans may offer in place of services or settings covered under the Nevada Medicaid State Plan and that are a medically appropriate, cost-effective alternative to a State Plan Covered Service. ILOS are optional for members to utilize. ILOS are designed to substitute for and potentially decrease utilization of covered Medicaid benefits, such as hospital care, nursing facility care, and Emergency Department (ED) use while improving quality of life. Nevada Medicaid has added the new ILOS benefit for its managed care program that are critical to addressing homelessness, improving outcomes, and lowering costs.

Molina offers short-term housing & transition services to support Medicaid recipients without a residence who have high medical or behavioral health needs with continuing their care or treatment as they transition into the community from an inpatient, correctional, or institutional/residential setting.

Providers who have members who may be eligible for ILOS should submit a referral to Care Management. Email: NV_CM@MolinaHealthcare.com
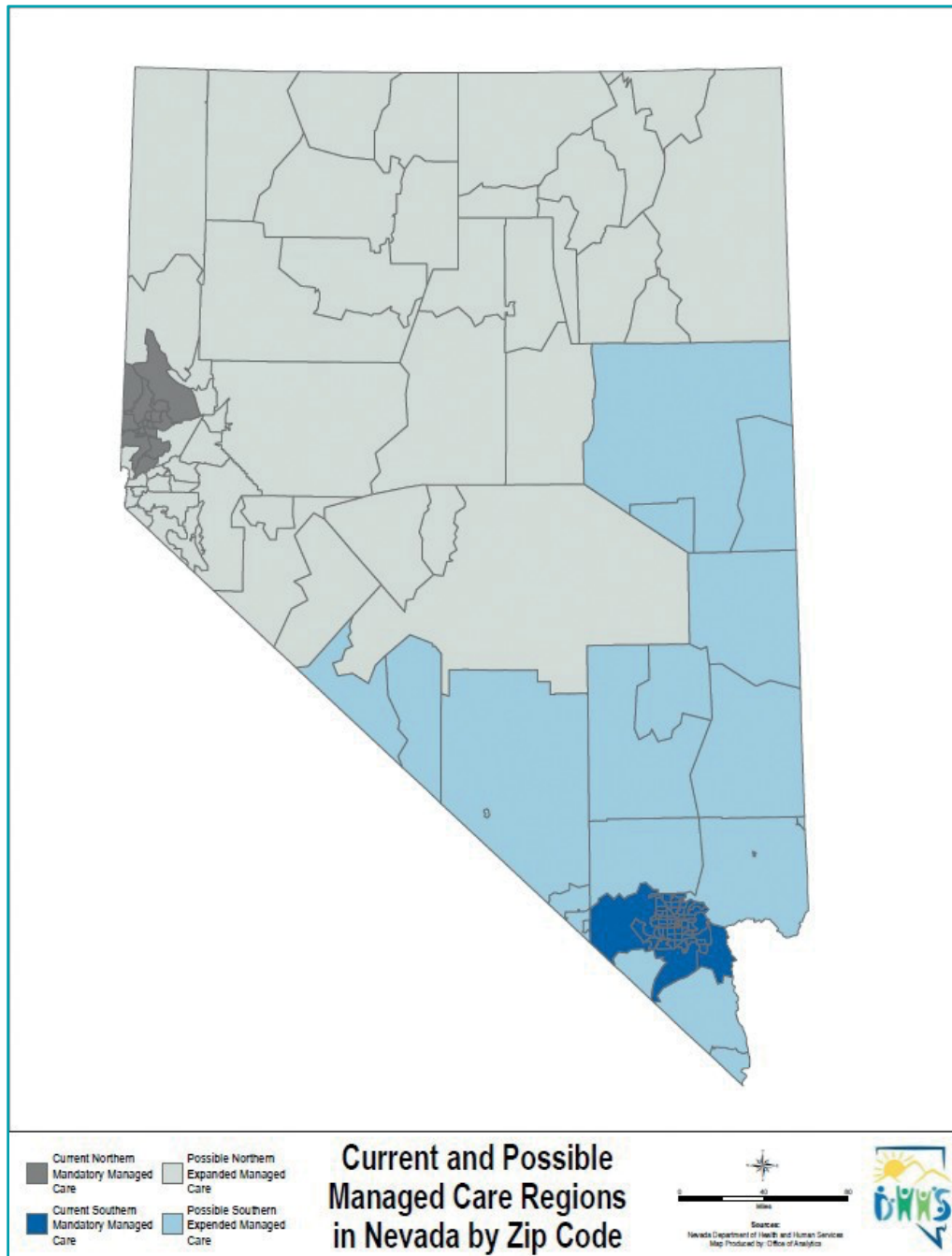
Quality

Molina maintains a Quality Department to work with Members and Providers in administering the Molina Quality Improvement (QI) Program. For additional information please refer to the **Quality** section of this Provider Manual.

Phone: (833) 685-2103

Molina Healthcare of Nevada, Inc. Service Area

Current and Possible Managed Care Regions in Nevada by Zip Code

2. Provider responsibilities

Non-discrimination in health care service delivery

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

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

Section 1557 Investigations

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

Molina Healthcare, Inc.
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802
Phone: (866) 606-3889 (TTY/TDD: 711)

Online: MolinaHealthcare.AlertLine.com

Email: civil.rights@MolinaHealthcare.com

For additional information, please refer to the Health and Human Services (HHS) website: federalregister.gov.

Facilities, equipment, personnel and administrative services

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 that 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 a National Committee for Quality Assurance (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.

Current information is critical for timely and accurate Claims processing. Providers must validate their Provider information on file with Molina at least once every (ninety) 90 days for correctness and completeness.

Providers must validate their Provider information on file with Molina at least once every 90 days for correctness and completeness.

Additionally, in accordance with the terms specified in your Provider Agreement, Providers must notify Molina of any changes, as soon as possible, but at a minimum thirty (30) calendar days in advance of any changes in any Provider information on file with Molina. Changes include, but not limited to:

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

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

Please visit our Provider Online Directory at MolinaProviderDirectory.com/NV to validate your information.

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

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.

All Molina Healthcare of Nevada Providers participating in a Medicaid network must be enrolled in the state Medicaid program to be eligible for reimbursement. If a Provider has not had a Medicaid number assigned, the Provider must apply for enrollment with the Nevada Division of Healthcare Financing and Policy meet the Medicaid Provider enrollment requirements for fee-for-service Providers by appropriate provider type at www.medicaid.nv.gov.

National Plan and Provider Enumeration System (NPPES) data verification

In addition to the above verification requirements, CMS recommends that Providers routinely verify and attest to the accuracy of their 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. 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

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 portal.

Electronic Claims include claims submitted via a clearinghouse using the EDI process and claims submitted through the Availity 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 portal within thirty (30) days of entering the Molina network.

Molina is committed to complying with all HIPAA Transactions, Code Sets, and Identifiers (TCI) standards. Providers must comply with all HIPAA requirements when using electronic solutions with Molina. Providers must obtain a National Provider Identifier (NPI) and use their NPI in HIPAA transactions, including Claims submitted to Molina. Providers may obtain additional information by visiting Molina's HIPAA Resource Center located on our website at MolinaHealthcare.com/NV.

Electronic solutions/tools available to Providers

Electronic Tools/Solutions available to Molina Providers include:

- Electronic Claims Submission Options
- Electronic Payment: EFT with ERA
- Provider Portal

Electronic Claim submission requirement

Molina strongly encourages Participating Providers to submit Claims electronically whenever possible. Electronic Claim 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 Claim submission options:

- Submit Claims directly to Molina via the Availity portal. See the Provider Portal Quick Reference Guide or contact your Provider Relations representative for registration and Claim submission guidance.
- Submit Claims to Molina through your EDI clearinghouse using Payer ID MLNNV, refer to our website MolinaHealthcare.com/NV for additional information.

While both options are embraced by Molina, submitting Claims via the Availity 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.

Availity 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 additional information on EDI Claims submission and Paper Claim Submissions, please refer to the Claims and Compensation section of this Provider Manual.

Electronic payment 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.

Molina which has partnered with ECHO Health, Inc. (ECHO), for payment delivery and 835 processing. On this platform, you may receive your payment via EFT/Automated Clearing House (ACH), a physical check, or a virtual card.

By default, if you have no payment preferences specified on the ECHO platform, your payments will be issued via Virtual Card. This method may include a fee that is established between you and your merchant agreement and is not charged by Molina or ECHO. You may opt out of this payment preference and request payment be reissued at any time by following the instructions on your Explanation of Payment and contacting ECHO Customer Service at (888) 834-3511 or edi@echohealthinc.com. Once your payment preference has been updated, all payments will go out in the method requested.

If you would like to opt-out of receiving a Virtual Card prior to your first payment, you may contact ECHO Customer Service at (888) 834-3511 or edi@echohealthinc.com and request that your Tax ID for payer Molina Healthcare of Nevada, Inc. be opted out of Virtual Cards.

Once you have enrolled for electronic payments you will receive the associated ERAs from ECHO with the Molina Payer ID. Please ensure that your practice management system is updated to accept the Payer ID referenced below. All generated ERAs will be accessible to download from the ECHO provider portal (providerpayments.com).

If you have any difficulty with the website or have additional questions, ECHO has a Customer Services team available to assist with this transition. Additionally, changes to the ERA enrollment or ERA distribution can be made by contacting the ECHO Health Customer Services team at (888) 834-3511.

As a reminder, Molina's Payer ID is MLNNV.

Once your account is activated, you will begin receiving all payments through EFT, and you will no longer receive a paper explanation of payment (EOP) (i.e., remittance) through the mail. You will receive 835s (by your selection of routing or via manual download) and can view, print, download, and save historical and new ERAs with a two-year lookback.

Additional instructions on how to register are available under the EDI/ERA/EFT tab on Molina's website at MolinaHealthcare.com/NV.

Availity portal

Providers and third-party billers can use the no cost Availity 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:
    o Submit Professional (CMS-1500) and Institutional (CMS-1450 [UB-04]) Claims with attached files.
    o Correct/Void Claims
    o Add attachments to previously submitted Claims
    o Check Claims status
    o View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP)
    o Create and manage Claim Templates
    o Create and submit a Claim Appeal with attached files.
- Prior Authorizations/Service Requests
    o Create and submit Prior Authorization/Service Requests
    o Check status of Authorization/Service Requests
- 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 Member for Covered Services is prohibited, except 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. Member Materials and Forms | Medicaid

Member eligibility verification

Possession of a Molina ID card does not guarantee Member eligibility or coverage. Providers should verify the 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.

Providers who contract with Molina may verify a Member's eligibility by checking the following:
- Availity portal
- Molina Provider Relations automated IVR system at (833) 685-2103

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

Health care 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, which 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/NV.

Additional information regarding In-Network Laboratory Providers and patient service centers can be found on the laboratory Providers' respective websites at appointment.questdiagnostics.com.

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 PCPs 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 the 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 that 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 Health Care Services section of this Provider Manual.

PCPs can 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 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 encouraged 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 improvement programs

Providers are expected to participate in Molina's Quality Programs and collaborate with Molina in conducting peer reviews 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 ten (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 section of this Provider Manual.

Participation in credentialing

Providers are required to participate in Molina's credentialing and re-credentialing process, if applicable, 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.

For additional information on Molina's Credentialing program, including Policies and Procedures, please refer to the Credentialing and Recredentialing section of this Provider Manual.

Delegation

Delegated entities must comply with the terms and conditions outlined in Molina's Delegated Services Addendum. For additional information on Molina's Delegation requirements and delegation oversight, refer to the Delegation section of this Provider Manual.

Primary care provider responsibilities

PCPs are responsible to:

- Serve as the ongoing source of primary and preventive care for Members
- Assist with coordination of care as appropriate for the Member's health care needs
- Recommend referrals to specialists participating with Molina
- Triage appropriately
- Notify Molina of Members who may benefit from Care Management
- Participate with all MOC-required activities including coordination of care during transitions

3. Cultural competency and linguistic services

Background

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the U.S. Department of Health and Human Services (HHS) and Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina complies with Section 1557 of the Patient Protection and Affordable Care Act, prohibiting discrimination in health programs and activities receiving federal financial assistance on the basis of race, color, and national origin, sex, age, and disability per Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1975 (29 U.S.C. § 794). Molina complies with applicable portions of the Americans with Disabilities Act of 1990. Molina also complies with all implementing regulations for the foregoing.

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/NV, from your local Provider Relations representative and by calling Molina Provider Relations at (833) 685-2103.

Non-discrimination of health care service delivery

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

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

1. You MAY NOT restrict your practice due to a Member's medical condition (whether physical or mental) or the anticipation of frequent or high-cost care requirements. You **MUST** post in a conspicuous location in your office, a Nondiscrimination Notice. A sample of the Nondiscrimination Notice that you will post can be found in the Member Handbook located at Member Materials and Forms | Medicaid (molinahealthcare.com)

2. You **MUST** post in a conspicuous location in your office, a Tagline Document, that explains how to access non-English language services. A sample of the Tagline Document that you will post can be found in the member materials and forms here: Member Materials and Forms | Medicaid (molinahealthcare.com)

3. If a Molina Member is in need of language assistance services while at your office, and you are a recipient of Federal Financial Assistance, you MUST take reasonable steps to make your services accessible to persons with limited English proficiency ("LEP"). You can find resources on meeting your LEP obligations at U.S. Department of Health and Human Services; See also, U.S. Department of Health and Human Services.

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

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

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

Cultural competency

Molina is committed to reducing health care disparities by understanding our Members communities, demographics, and the barriers to care they may encounter. This helps us provide culturally humble and appropriate care. 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 ensures that cultural competency is considered in every interaction with our members, enhancing service delivery and program development.

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 Relations and online/ web-based training modules. Web-based training modules can be found on Molina's website at https://www.MolinaHealthcare.com/providers/nv/medicaid/health/cme.aspx

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

- Provider written communications and resource materials.
- Online cultural competency Provider training modules.
- Integration of cultural competency concepts and nondiscrimination of service delivery into Provider communications.

Integrated quality improvement

Molina ensures Members 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 Limited English Proficiency (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/NV and information delivered in digital form meet Section 508 accessibility requirements to support Members with visual impairments.

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

Access to interpreter services

Providers may request interpreters for Members whose primary language is other than English by calling Molina's Contact Center 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 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. They may lack the necessary language skills and professional training, which can lead to inaccuracies and breaches of confidentiality. Using a professional interpreter ensures clear and accurate communication while maintaining patient privacy.

All eligible Members with Limited English Proficiency (LEP) are entitled to receive interpreter services. Pursuant to Title VI of the Civil Rights Act of 1964, services provided for Members with LEP, limited reading proficiency, or limited hearing or sight are the financial responsibility of the Provider. Under no circumstances are Molina Members responsible for the cost of such services. "Written procedures are to be maintained by each office or facility regarding their process for obtaining such services. Molina is available to assist providers with locating these services if needed. These guidelines align with the principles of the National CLAS Standards to ensure culturally and linguistically appropriate services.

An individual with LEP has a limited ability or inability to read, speak, or write English well enough to understand and communicate effectively (whether because of language, cognitive or physical limitations).

Molina Members are entitled to:

- Be provided with effective communications with medical Providers as established by the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, and the Civil Rights Act of 1964.

- Be given access to Care Managers trained to work with individuals with cognitive impairments.

- Be notified by the medical Provider that interpreter services are available at no cost.

- Decide, with the medical Provider, to use an interpreter and receive unbiased interpretation.

- Be assured of confidentiality, as follows:

- Interpreters must adhere to Health and Human Service Commission (HHSC) policies and procedures regarding confidentiality of Member records.

  - Interpreters may, with Member written consent, share information from the Member's records only with appropriate medical professionals and agencies working on the Member's behalf.
  - Interpreters must ensure that this shared information is similarly safeguarded.

- Have interpreters, if needed, during appointments with the Member's Providers and when talking to the health plan.

Interpreters include people who can speak the Member's native language, assist with a disability or help the Member understand the information.

When Molina Members need an interpreter, limited hearing and/or limited reading services for health care services, the Provider should:

- Verify the Member's eligibility and medical benefits.
- Inform the Member that an interpreter, limited hearing, and/or limited reading services are available.
- Molina is available to assist Providers with locating these services if needed:
  - Providers needing assistance finding onsite interpreter services
  - Providers needing assistance finding translation services Providers with Members who cannot hear or have limited hearing ability may use the National TTY/TDD Relay service at 711.
  - Providers with Members with limited vision may contact Molina for documents in large print, Braille or audio version.
- Providers with Members with limited reading proficiency (LRP)
- The Molina Contact Center representatives will verbally explain the information, up to and including reading the documentation to the Members or offer the documents in audio version.

Documentation

As a contracted Molina Provider, your responsibilities for documenting Member language services/ needs in the Member's medical record are as follows:

- Record the Member's language preference in a prominent location in the medical record. This information is provided to you on the electronic Member lists that are sent to you each month by Molina.
- Document all Member requests for interpreter services.
- Document who provided the interpreter service. This includes the name of Molina's internal staff or someone from a commercial interpreter service vendor. Information should include the interpreter's name, operator code and vendor.
- Document all counseling and treatment done using interpreter services.
- Document if a member insists on using a family member, friend, or minor as an interpreter or refuses the use of interpreter services after notification of their right to have a qualified interpreter at no cost.

Members who are deaf or hard of hearing

The TTY/TDD connection can be reached by dialing 711. This connection provides access to the Molina 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. To ensure availability of the service, requests should be made at least three (3) business days in advance of an appointment. In most cases, Members will have made this request via Molina Contact Center.

24-hour 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 at (833) 685-2104 or TTY/TDD 711. The telephone numbers are also printed on membership cards.

Program and policy review guidelines

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

- Annual collection and analysis of race, ethnicity and language data from:
  - Eligible individuals to identify significant culturally and linguistically diverse populations within a plan's membership.
  - Contracted Providers to assess gaps in network demographics.

- Revalidate data at least annually.
- Local geographic population demographics and trends derived from publicly available sources (Community Health Measures and State Rankings Report).
- Applicable national demographics and trends derived from publicly available sources.
- Assessment of Provider network.
- Collection of data and reporting for the Diversity of Membership HEDIS® measure.
- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages.
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations.
- Analysis of HEDIS® and Consumer Assessment of Healthcare Providers and Systems CAHPS®/ Qualified Health Plan (QHP) Enrollee Experience survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

4. Member rights and responsibilities

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:
Member Rights and Responsibilities.

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/TDD: 711for persons with hearing impairments.

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 Contact Center to find out how to get a second opinion. Second opinions may require Prior Authorization.

5. Eligibility, enrollment, disenrollment

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 12 months unless they become ineligible for the program and are disenrolled.

No eligible Member shall be refused enrollment or re-enrollment, have their 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 section of this Provider manual.

Molina reserves the right not to re-enroll a member with our health plan if the Member was previously disenrolled from Molina as a 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 thirty (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 thirty (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 Relations at (833) 685-2103
- Availity portal

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:

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 recipient requests 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

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 you have questions about whether a service is covered or requires prior authorization, please reference the benefits and prior authorization tools on the Molina website and Availity 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.

Service covered by Molina

Molina covers the services 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 Availity 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/NV.

Obtaining access to certain Covered Services

Non-preferred Drug Exception Request process

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

- For a Standard Exception Request, the Member and/or Member's Representative and the prescribing Provider will be notified of Molina's decision within twenty-four (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 twenty-four (24) hours of receiving the complete request.
- Members will also have the right to appeal a denial decision, per any state requirements.

Molina will allow a seventy-two (72) hour emergency supply of prescribed medication for dispensing at any time that prior authorization is not available. Pharmacists will use their professional judgment regarding whether or not there is an immediate need every time the seventy-two (72) hour option is utilized. This procedure will not be allowed for routine and continuous overrides.

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. For additional information about our prior authorization process, including a link to the Prior Authorization Request Form, please refer to the Health Care Services section of this Provider Manual. Physician-administered drugs require the appropriate National Drug Code (NDC) except for vaccinations or other drugs as specified by CMS.

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. For additional information about our Prior Authorization process, including a link to the PA request form, please refer to 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 Member Contact Center at (833) 685-2102. Molina's Nurse Advice Line (833) 685-2104 is available 24 hours a day, seven days a week, 365 days per year for mental health or substance abuse needs. The services Members receive will be confidential. Additional detail regarding Covered Services and any limitations can be obtained in the Summary of Benefits linked above, or by contacting Molina.

Emergency mental health or substance use disorder services

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

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

Out-of-area emergencies

Members having a 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 twenty-four (24) to forty-eight (48) hours

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

Emergency transportation

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

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. This requires a written prescription from the Member's doctor. Examples of non-emergency medical transportation include, but are not limited to, litter vans and wheelchair-accessible vans. Members must have Prior Authorization from Molina for ground and air ambulance services before the services are given. Prior Authorization is not required for vans, taxis, etc. Additional information regarding the availability of this benefit is available by contacting Provider Relations at (833) 685-2103.

Members who need assistance should contact MTM directly or Molina Member Services for assistance at least five business days in advance of or Molina Member Services at least five business days before 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.

Preventive Health Guidelines (MolinaHealthcare.com)

We need your help conducting these regular exams in order to meet the targeted State and Federal standards. If you have questions or suggestions related to well 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.

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

Well child visits and Early Periodic Screening Diagnosis and Treatment (EPSDT) guidelines

The Federal 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 physical 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 may 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-childcare, 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

Emergency services

Emergency services means: An emergency service is any health care service provided to evaluate and/or treat any medical condition such that a prudent layperson possessing an average knowledge of medicine and health, believes that immediate unscheduled medical care is required.

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

Nurse Advice Line

Members may call the Nurse Advice Line any time they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, 7days a week, 365 days a year, 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

The tools and services described here are educational support for Molina Members and may be changed at any time to meet their needs.

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

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

Telehealth and telemedicine services

Molina Members may obtain physical and behavioral health 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.
- Members have the option of receiving PCP services through telehealth. If they choose to use this option, the Member must use a Network Provider who offers telehealth.
- 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 must be coded in accordance with applicable reimbursement policies and billing guidelines. Rendering Providers must comply with applicable federal and state guidelines for telehealth service delivery.

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

Introduction

Health Care Services is comprised of Utilization Management (UM) and Care Management (CM) departments that work together to achieve an integrated model based upon empirically validated best practices that have demonstrated positive results. Research and experience show that a higher-touch, Member-centric care environment for at-risk Members supports better health outcomes. 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 UM program include pre-service authorization review and inpatient authorization management that includes pre- admission, admission and concurrent review, medical necessity review, and restrictions on the use of out-of-network Providers.

Utilization Management (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 a Member's care by:

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

Key functions of the UM program

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

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

For more information about Molina's UM program, or to obtain a copy of the HCS Program description, clinical criteria used for decision making, and how to contact an UM reviewer, access the Molina website or contact the UM department. You may also get in touch with your Provider Relations representative and by calling Molina Provider Relations at (833) 685-2103.

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

An organizational determination is any decision made by Molina or the delegated Medical Group/ IPA or other delegated entity with respect to the following:

- Determination to authorize services (favorable determination);
- Determination to delay, modify or deny authorization of requested services (adverse determination); Discontinuation of authorization for a service; Prior Authorization for temporarily out-of-the-area renal dialysis services; and,
- Prior Authorization of post stabilization care or urgently needed services.
- Emergency services do not require prior authorization.

Molina follows a hierarchy of medical necessity decision-making, with Federal and State regulations taking precedence. It covers all services and items required by State and Federal regulations.

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

Requests for authorization not meeting medical necessity 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 clinical professional as appropriate may determine to delay, modify, or deny authorization of services to a member.

Providers can contact Molina's Healthcare Services department at (833) 685-2103, 8 a.m. to 6 p.m. Monday through Friday to obtain Molina's UM Criteria. Providers may also contact Provider Relations or their Provider Relations representative to obtain Molina's UM Criteria.

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

Medical Necessity

"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 medial 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, by itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

MCG Cite for Guideline Transparency and MCG Cite AutoAuth

Molina has partnered with MCG Health to implement Cite for Guideline Transparency. Providers can access this feature through the Availity portal. With MCG Cite for Guideline Transparency, Molina can share clinical indications with Providers.

The tool operates as a secure extension of Molina's existing MCG investment and helps meet regulations around transparency for delivery of care:

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

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

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

Cite AutoAuth can be accessed via the Availity portal and is available 24 hours per day/7 days per week. This method of submission is you're the primary submission route for advanced imagiing requests. Molina will also be rolling out additional services throughout the year. Clinical information submitted with the PA will be reviewed by Molina. This system will provide quicker and more efficient processing of your authorization request, and the status of the authorization will be available immediately upon completion of your submission.

What is Cite AutoAuth and how does it work?

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

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

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, Molina clinical policies 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 Provider Services Agreement with Molina Healthcare of Nevada. 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/NV.

Providers are encouraged to use the Availity 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 National Provider Identifier (NPI) number

- Member diagnosis and International Classification of Diseases 10th Revision (ICD-10) codes
- Requested service/procedure, including all appropriate CPT and HCPCS codes, units, and dates of service.
- Location where service will be performed
- Clinical information sufficient to document the medical necessity of the requested service is required including:
  o Pertinent medical history (include treatment, diagnostic tests, examination data).
  o Requested length of stay and level of care (for inpatient requests)
  o Rationale for expedited processing, if requested as urgent/expedited. The urgent/expedited service request designation should only be used if the treatment is required to prevent serious deterioration in the member's health or could jeopardize their ability to regain maximum function. Requests outside of this definition will be handled as routine/non-urgent.

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 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.

(see MHI update below) Molina will make an organizational determination as promptly as the Member's health requires and no later than contractual and regulatory requirements. Expedited timeframes are followed when the provider indicates, or if we determine that a standard authorization decision timeframe could jeopardize a Member's life or health.

Providers who request prior authorization for services and/or procedures may request to review the criteria used to make the final decision. A Molina Medical Director is available to discuss medical necessity decisions with the requesting Provider at (833) 685-2103 during business hours.

Upon approval, the requestor will receive an authorization number. The number may be provided by telephone or fax or via the Availity portal. 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 review

Upon receipt of an adverse determination, the Provider (peer) may request a peer-to- peer discussion within five (5) business from the notification.

A "peer" is considered the Member's or Provider's clinical representative (licensed medical professional) Contracted external parties, administrators, or facility UM staff can only request that a peer-to-peer telephone communication be arranged and performed but the discussion should be performed by a peer.

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

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

If a Medical Director is not immediately available, the call will be returned within two (2) business days. Every effort will be made to return calls as expeditiously as possible.

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/NV website:

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

The most current Prior Authorization Guidelines and the Prior Authorization Request Form can be found on the Molina website at Provider Forms.

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

- Create and submit Prior Authorization Requests
- Check the 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.

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

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 5 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.

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

After business hours, Providers can also utilize fax and the Availity 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: Emergency services means, with respect to an individual enrolled with an organization, 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. The Contractor must not require the services to be prior or post-authorized.

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.

Post-Stabilization Care Services are covered services that are:

1. Related to an Emergency Medical Condition;
2. Provided after the Member is stabilized; and
3. Provided to maintain the stabilized condition, or under certain circumstances, to improve or resolve the Member's condition.

Molina defines "post stabilization care services" as covered services, related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 CFR §438.114(e), to improve or resolve the member's condition. Molina is financially responsible for post stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other Molina representative but administered to maintain the member's stabilized condition within one hour of a request to Molina for the pre-approval of further post stabilization services if:

1. Molina does not respond to a request for prior approval within one hour.
2. Molina cannot be contacted.
3. The Molina representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, Molina must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in 42 CFR §422.113(c)(3) is met.

Molina's financial responsibility for post stabilization care services it has not pre-approved ends when:

1. A plan physician with privileges at the treating hospital assumes responsibility for the member's care.
2. A plan physician assumes responsibility for the member's care through transfer.

3. An MCO representative and the treating physician reach an agreement concerning the member's care.

4. The member is discharged.

Providers requesting an inpatient admission as a Post Stabilization service must request this type of service by contacting Molina at (833) 685-2103.

Inpatient admission requests (not including Post Stabilization requests) received via fax will be processed within standard inpatient regulatory and contractual time frames.

Molina also provides Members with 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 may only be covered until the Member has stabilized sufficiently to transfer to an available participating facility. Services provided after stabilization in a non-participating facility are not covered and the Member maybe 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 Planned admissions

Molina requires prior authorization for all elective inpatient procedures to any facility. Facilities are required to also notify Molina within twenty-four (24) hours or by the following business day once an 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 twenty-four (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 may result in a denial of authorization for the inpatient stay.

Inpatient at the time of termination of coverage

When a Member's coverage with Molina terminates during a hospital stay, Molina will cover the last day of eligibility.

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 twenty-four (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 federal and state guidelines along with evidence-based criteria to determine if the collected clinical information for requested services is "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of malformed body member" by meeting all coverage, coding, and medical necessity requirements (refer to the Medical Necessity section of this Provider Manual).

Discharge planning

The goal of discharge planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission.

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 twenty-four (24) hours of discharge, the hospital must submit notification of admission for authorization of services. The subsequent admission will be treated as a new/separate admission.

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 may 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. In those cases, a Medical Necessity review will be performed. Decisions, in this circumstance, will be based on medical necessity.

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 practitioners 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 existence of coverage. Molina does not specifically reward Practitioners or other individuals for issuing denials of coverage or care. 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.

Avoiding Conflict of Interest

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

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

Coordination of Care and Services

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

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

Continuity of Care and Transition of Members

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

- Acute condition or serious chronic condition – Following termination, the terminated Provider will continue to provide covered services to the Member up to ninety (90) days or longer, if necessary, for a safe transfer to another Provider as determined by Molina or its delegated Medical Group/IPA.
- 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 themself, or unable to protect themself against significant harm or exploitation. When working with children one may encounter situations suggesting abuse, neglect and/or unsafe living environments.

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

- Physicians, dentists, interns, residents, or nurses.
- Public or private school employees or childcare 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: ClarkCounty.gov/Protective Services

Washoe County (Reno/Sparks) Telephone:

(833) 900-SAFE (7233)
Website: Washoe County Child Protective Services

<u>All Other Counties</u>

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 developed, and upon any change in condition. 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 the member's 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 ninety (90) 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. Members can request to be enrolled or dis-enrolled in these programs at any time. Our Molina My Health programs include:

- Molina My Health -Weight Management
- Molina My Health -Tobacco Cessation
- Molina My Health -Nutrition

For more information about these programs, please call (833) 269-7830, or TTY/TDD at 711 Relay. **Fax:** (800) 642-3691.

Maternity Screening and High-risk Obstetrics

Molina provides prenatal health education, resources, and screenings for all pregnant members as well as screening services to identify high risk pregnancy conditions. Case managers with specialized OB training provide additional support and health education for Members with identified high risk pregnancies to ensure best outcomes for Members and their newborns during pregnancy, delivery and through twelve months 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 Provider Forms) within one (1) working day of the first prenatal visit and/or positive pregnancy test. The form should be emailed to Molina at MHIHIGHRISKOB@MolinaHealthCare.com or faxed to (866) 440-9791.

Member newsletters

Member Newsletters are posted on the Molinahealthcare.com/Members/NV/Newsletters website twice a year. The articles cover topics asked by Members and offer tips to help Them stay healthy.

Member Health Education Materials

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

Program Eligibility Criteria and Referral Source

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

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

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

Provider Participation

Provider resources and services may include:

- Annual Provider feedback letters containing a list of patients identified with the relevant disease
- Clinical resources such as patient assessment forms and diagnostic tools
- Patient education resources

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

Additional information on Health Management programs is available from your local Molina Healthcare Services department toll free at (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 Care Management 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 a licensed professional 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 complete an assessment with 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 Care Management

Members with high-risk medical conditions and/or other care needs may be referred by their PCP or specialty care Provider to the 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, 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 or 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
- Adults 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

Personal Care Services

Personal Care Services: Services performed in accordance with a written service plan developed in conjunction with the Member or the representative and based on the needs of the Member being served as determined by a functional assessment. Assistance may be in the form of direct hands-on assistance or cueing the individual to perform the task, and relates to the performance ADLs and IADLs. Personal Care Services may be provided in the home or in locations outside the home, including employment sites or wherever the need for Personal Care Services occurs. The time authorized for services is documented in the approval service plan, regardless of the location of services.

8. Behavioral health

Overview

Molina provides a Behavioral Health benefit for Members. Molina takes an integrated, collaborative approach to behavioral health care, encouraging participation from PCPs, Behavioral Health, and other specialty care Providers to ensure "whole person" care. Molina complies with the most current Mental Health Parity and Addiction Equity Act requirements.

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, Fax (775) 460-4900. Providers requesting after-hours authorization for these services should utilize the Availity portal or 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. For additional information please refer to 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 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 aged 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, aged six through 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 through five 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. A formal referral form or Prior Authorization is not needed for a Member to self-refer or be referred to a PCP or Behavioral Health Provider.

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

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 and to occur within (7) days of 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 amongst 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 care management team includes licensed nurses and clinicians with behavioral health experience to support Members with mental health and/or Substance Use Disorder (SUD) needs. Members with high-risk psychiatric, medical, or psychosocial needs may be referred by a Behavioral Health or Primary Care 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: NV_CM@MolinaHealthcare.com

For additional information on the Care Management Program please refer to the Care Management subsection found in the Health Care Services section 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 can obtain needed health services within the acceptable appointment timeframes. Please refer to the Access to Care section of the Quality section of this Provider Manual for specific access to appointment details.

All Members receiving inpatient psychiatric services must be scheduled for a psychiatric outpatient appointment prior to discharge. The aftercare outpatient appointment must include the specific time, date, location, and name of the Provider. This appointment must occur within seven (7) calendar days of the discharge date. If a Member misses a behavioral health appointment, the Behavioral Health Provider must contact the Member within twenty-four 24 hours of a missed appointment to reschedule.

Behavioral Health Crisis Line

Molina has a Behavioral Health Crisis Line that may be accessed by Members 24/7 year-round. The Molina Behavioral Health Crisis Line is staffed by behavioral health clinicians to provide urgent crisis intervention, emergent referrals and/or triage to appropriate supports, resources, and emergency response teams. Members experiencing psychological distress may access the Behavioral Health Crisis Line by calling the Member Services number as listed on the back of the Molina Member ID Card at (833) 685-2102 or by calling the Nurse Advice Line at (833) 685-2104.

National Suicide Lifeline

988 is the National Suicide Lifeline. Anyone in need of suicide or mental health crisis support (or anyone worried about someone else), can receive free and confidential support 24 hours a day, 7 days a week, 365 days per year, by dialing 988 from any phone.

Behavioral Health Tool Kit for Providers

Molina has developed an online Behavioral Health Tool Kit to provide support with screening, assessment, and diagnosis of common behavioral health conditions, plus access to Behavioral Health HEDIS® Tip Sheets and other evidence-based guidance, training opportunities for Providers, 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/ NV Provider website.

9. Quality

Maintaining quality improvement processes and programs

Molina works with Members and Providers to maintain a comprehensive Quality Improvement (QI) Program. The Molina Quality department can be reached 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 QI program. For a complete copy of Molina's Quality Improvement Program, you can contact your Provider Relations representative or call the telephone number above to receive a written copy.

Molina has established a QI Program that complies with regulatory requirements and accreditation standards. The QI 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 QI Program in place
- Comply with and participate in Molina's QI 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 health practices for our Members through our safety program, pharmaceutical management and care management/health 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 medical 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 medical record
- Medical records are stored away from patient areas and preferably locked.
- Medical records are available during each visit and archived records are available within twenty-four (24) hours.
- If hard copy, pages are securely attached to the medical record, and records are organized by dividers or color-coded when the thickness of the record dictates.
- If electronic, all those with access have individual passwords.
- Record keeping is monitored for quality and HIPAA compliance, including privacy of confidential information, such as race, ethnicity, language, and sexual orientation and gender identity.

- Storage maintenance for the determined timeline and disposal are managed per record management processes.
- Process is in place 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, but not be limited to, the following information. All medical records should contain:

- The patient's name or ID number on each page in the record
- The patient's 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.
- A list of all Providers who participate in the Member's care.
- Information about services that are 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 thirty (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 shows 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, that include 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 as 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 and follow-up care, inpatient and outpatient care, including hospital discharge summaries, hospital history and physicals, and operative reports.

- Labor and delivery record for any child seen since birth.

- Notation concerning cigarettes, alcohol, and substance use 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 the 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 thirty [30] days from the date of request).

- When a Member changes PCPs, the medical record must be forwarded to the new Provider within ten (10) business days of the request's receipt.

- A storage system for inactive Member medical records that allows retrieval within
  - twenty-four (24) hours, is consistent with State and Federal requirements, and the record is maintained for not less than ten (10) years from the last date of treatment or for a minor, one (1) year past their 20th birthday but, never less than ten (10) years.

- An established and functional data recovery procedure in the event of data loss.

Confidentiality

Molina Providers shall develop and implement confidentiality procedures to guard Member protected health information, in accordance with HIPAA privacy standards and all other applicable Federal and State regulations. This should include, and is not limited to, the following:

- Ensure that medical information is released only in accordance with applicable Federal or State Law in pursuant to court orders or subpoenas.
- Maintain records and information in an accurate and timely manner.
- Ensure timely access by Members to the records and information that pertain to them.
- Abide by all Federal and State Laws regarding confidentiality and disclosure of medical records or other health and enrollment information.
- Protect medical records from unauthorized access.
- Restrict access to computerized confidential information is restricted.
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.
- Educate and train all staff on handling and maintaining protected health care information.
- Ensure that confidential information, such as patient race, ethnicity, preferred language, sexual orientation, gender identity, and social determinants of health is protected.

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.

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 (2) types of Advance Directives:

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

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

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

Members who would like more information are instructed to contact Member Contact Center s or are directed to the Caring Info website at CaringInfo.org for forms available to download. Additionally, the Molina website offers information to both Providers and Members regarding advance directives, with a link to forms that can be downloaded and printed.

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

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 regulations give Members the right to file a complaint with Molina or the State survey and certification agency if the Member is dissatisfied with Molina's handling of Advance Directives and/or if a Provider fails to comply with Advance Directives instructions.

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

Molina expects that there will be documented evidence of the discussion between the Provider and the Member during routine medical record reviews.

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 surveyed include PCPs (family/general practice, internal medicine, and pediatric), OB/GYN (high-volume specialists), Oncologist (high-impact specialists), and Behavioral Health Providers. 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 PCP or their designee must be available 24 hours a day, 7 days a week to Members.

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 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 a day; 7 days a 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
Non-life-threatening Emergency	Within 6 hours
Urgent Care	Within 3 calendar days
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, 7 days a week.
This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with an Emergency to hang-up and call 911 or go immediately to the nearest emergency room. Voicemail alone after-hours is not acceptable.

Appointment scheduling

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

1. The Provider must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments.

2. A process for documenting missed appointments must be established. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record and the Provider is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the medical record. If a second appointment is missed, the Provider is to notify the **Molina Provider Relations department at** (833) 685-2103 (TTY/TDD: 711).

3. When the Provider must cancel a scheduled appointment, the Member is given the option of seeing an associate or having the next available appointment time.

4. Special needs of Members must be accommodated when scheduling appointments. This includes, but is not limited to wheelchair-using Members and Members requiring language interpretation.

5. A process for Member notification of preventive care appointments must be established. This includes, but is not limited to immunizations and mammograms.

6. A process must be established for Member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test results or the scheduling of procedures which must be performed prior to the next visit.

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

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 obstetric and gynecological services. Member access to obstetric and gynecological services is monitored to ensure Members have direct access to participating Providers for obstetric 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 and Health Equity Transformation 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 an annual assessment of provider office 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 appointments and after-hours access.

Analysis of access data includes assessing performance against established standards, reviewing trends over time, and identifying barriers. The results of analysis are reported to the Quality Improvement and Health Equity Transformation 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 and Health Equity Transformation Committee.

Quality of provider office sites

Molina Providers are to maintain office-site and medical record keeping practice standards. Molina continually monitors Member appeals and complaints/grievances for all office sites to determine the need for 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 them. 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 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 the 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 (2) 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 (1) CPR-certified employee is available.
- Yearly OSHA training (Fire, Safety, Blood-borne Pathogens, etc.) is documented for offices with ten (10) or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, and evidence of a hazardous waste management system in place.
- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers, or labels are possible alternative methods. Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling, and triage phones are best placed at another location.
- Medical records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked.
- A CLIA waiver is displayed when the appropriate lab work is run in the office.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double-locked. Medication and sample access 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.

Early and Periodic Screening, Diagnostic and Treatment services to enrollees under 21 years of age

Molina maintains systematic and robust monitoring mechanisms to ensure all required EPSDT Services to Enrollees under twenty-one (21) years of age are timely according to required preventive guidelines. All Enrollees under twenty-one (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 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). Periodic objective screening for social emotional development using a recognized, standardized tool.

- Perinatal depression for mothers of infants in the most appropriate clinical setting, e.g., at the pediatric, behavioral health or OB/GYN visit.

- 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 thirty (30) calendar days. Follow-up to ensure resolution is conducted at regular intervals until compliance is achieved. The information and any response made by the Provider are included in the Providers permanent credentials file. If compliance is not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from Network participation or closed to new Members.

Quality improvement activities and programs

Molina maintains an active Quality Improvement Program. The Quality Improvement Program provides structure and key processes to carry out our ongoing commitment to improvement of care and service. The goals identified are based on an evaluation of programs and services; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

Health management and care management

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

For additional information, please refer to the Health Management and Case Management headings in the Health Care 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.

Molina CPGs include the following:

- Acute Stress and Post-Traumatic Stress Disorder (PTSD)
- Anxiety/Panic Disorder
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Bipolar Disorder
- Children with Special Health Care Needs
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Failure in Adults
- Homelessness-Special Health Care Needs
- Hypertension
- Obesity
- Opioid Management
- Perinatal Care
- Pregnancy Management
- Schizophrenia
- Sickle Cell Disease
- Substance Use Treatment
- Suicide Risk
- Trauma-Informed Primary Care

All CPG are updated at least annually, and more frequently, as needed when clinical evidence changes, and are approved by the Quality Improvement and Health Equity Transformation Committee. In fact, a review is conducted at least monthly to identify new additions or modifications. On an annual basis, or when changes are made during the year, CPGs are distributed to Providers at MolinaHealthcare.com/providers/quality and the Provider Manual. Notification of the availability of the Clinical Practice Guidelines is published in the Molina Provider Newsletter.

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 the Centers for Disease Control and Prevention (CDC), in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines. Diagnostic preventive procedures include but are not limited to:

- Adult Preventive Services Recommendations (U.S. Preventive Services Task Force). Links to current recommendations are included on Molina's website.

- Recommendations for Preventive Pediatric Health Care (Bright Futures/American Academy of Pediatrics). Links to current recommendations are included on Molina's website MolinaHealthcare.com/NV (under Health Resources).

- Recommended Adult Immunization Schedules for Ages 19 or Older, United States, These recommendations are revised every year by the Centers for Disease Control and Prevention. Links to current recommendations are included on Molina's website. MolinaHealthcare.com/NV (under Health Resources).

- Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States. These recommendations are revised every year by the Centers for Disease Control and Prevention. Link to current recommendations are included on Molina's Website MolinaHealthcare.com/NV (under Health Resources).

All preventive health guidelines are updated at least annually and more frequently as needed when clinical evidence changes and are approved by the Quality Improvement and Health Equity Transformation Committee. In fact, a review is conducted at least monthly to identify new additions or modifications. On an annual basis, or when changes are made during the year Preventive Health Guidelines are distributed to Providers at MolinaHealthcare.com/NV (or when changes are made during the year) and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Provider Newsletter.

Cultural and linguistic appropriate 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.

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. 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/NV.

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 used to evaluate the effectiveness of multiple quality improvement activities and clinical programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the effectiveness of these programs.

Selected HEDIS® results are provided to federal and state regulatory agencies and accreditation organizations. The data are also used to compare against 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 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 (for Medicare). 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 services. This feedback is collected at least annually to understand how our Members rate their experiences in getting treatment, communicating with their clinicians, receiving treatment and information from the plan, among other areas.

Provider satisfaction survey

Recognizing that HEDIS® and CAHPS® both focus on Member experience with health care providers and health plans, Molina conducts a Provider Satisfaction Survey annually. The results from this survey are very important to Molina, as this is one of the primary methods 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.
- Provide timely response to medical record requests.
- 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® 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

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

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

Your role as a provider

As a Provider, complete and accurate documentation in a medical record is critical to a member's quality of care. We encourage Providers to record all diagnoses to the highest specificity. 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 the CMS National Correct Coding Initiative (NCCI).
- Use the correct ICD-10 code by documenting the condition to the highest level of specificity.
- Only use diagnosis 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.

Contact information

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

Interoperability

The 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). The CDA 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) Consolidated Clinical Data Architecture (CCDA) standard.

The 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.

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

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

11. Compliance

Fraud, waste, and abuse

Introduction

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

Molina's Special Investigation Unit (SIU) supports 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

Our mission is to pay claims correctly the first time, and that mission begins with the understanding that we need to proactively detect Fraud, Waste and Abuse, correct it, and prevent it from reoccurring. Since not all Fraud, Waste or Abuse can prevented, Molina employs processes that retrospectively detect and address Fraud, Waste or Abuse that may have already occurred. Molina strives to detect, prevent, investigate, and report suspected health care fraud, waste, and abuse in order to reduce health care cost and to promote quality health care.

Regulatory requirements

Federal False Claims Act

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

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

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

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

Deficit Reduction Act

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

As a contractor doing business with Molina, Providers and their staff have the same obligation to report any actual or suspected violation of 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 backpay 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 (42 U.S.C. § 1320a-7b(b))

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

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

What is AKS?

AKS statutes and regulations prohibit paying or receiving anything of value to induce or reward patient referrals or the generation of business involving any item or service payable by Federal and State health care programs. The phrase "anything of value" can mean cash, discounts, gifts, excessive compensation, contracts not at fair market value, etc. **Examples** of prohibited AKS actions include a health care Provider who is compensated based on patient volume, or a Provider who offers remuneration to patients to influence them to use their services.

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

Marketing Guidelines and Requirements

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

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

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

Stark statute – The Physicians Self-Referral Law (Stark Law) prohibits physicians from referring patients to receive "designated health services" payable by Medicare of Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. Stark law prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals. "Designated health services" are identified in the Physician Self-Referral Law [42 U.S.C. § 1395nn].

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)
Code of Federal Regulations.

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, which are key in identifying fraud, waste, and abuse. If the Claims Examiner suspects fraudulent, abusive, or wasteful billing practices, the billing practice is documented and reported to the SIU through our Compliance Alert line.

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

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

Prepayment fraud, waste, and abuse detection Activities

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

Molina has a pre-payment Claims auditing process that identifies frequent correct coding billing errors ensuring that Claims are coded appropriately according to State and Federal coding guidelines. Code edit relationships and edits are based on guidelines from specific State

Medicaid Guidelines, Centers for Medicare & 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 where upon 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 the 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 164.501 and 45 CFR 164.502). 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.

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
Phone: (775) 684-1100, (702) 486-3420

Complaint form available at: ag.nv.gov/Complaints/File_Complaint/

Division of Health Care Financing and Policy (DHCFP)
1100 East William Street, Suite 101
Carson City, Nevada 89701

HIPAA Requirements and Information

HIPAA (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 Code of Federal Regulations
- Health Information Technology for Economic and Clinical Health Act, (HITECH Act)

Artificial intelligence

Provider shall comply with all applicable state and federal laws and regulations related to artificial intelligence and the use of artificial intelligence tools (AI). Artificial Intelligence or AI means a machine-based system that can, with respect to a given set of human-defined objectives, input or prompt, as applicable, make predictions, recommendations, data sets, work product (whether or not eligible for copyright protection), or decisions influencing physical or virtual environments. The Provider is prohibited from using AI for any functions that result in a denial, delay, reduction, or modification of covered services to Molina Members including, but not limited to utilization management, prior authorizations, complaints, appeals and grievances, and quality of care services, without review of the denial, delay, reduction or modification by a qualified clinician.

Notwithstanding the foregoing, the Provider shall give advance written notice to your Molina Contract Manager (for any AI used by the Provider that may impact the provision of Covered Services to Molina Members) that describes (i) Providers' use of the AI tool(s) and (ii) how the Provider oversees, monitors and evaluates the performance and legal compliance of such AI tool(s). If the use of AI is approved by Molina, the Provider further agrees to (i) allow Molina to audit Providers' AI use, as requested by Molina from time to time, and (ii) to cooperate with Molina with regard to any regulatory inquiries and investigations related to Providers' AI use related to the provision of covered services to Molina Members.

If you have additional questions, please contact your Molina Contract Manager.

Applicable laws

Providers must understand all State and Federal health care privacy Laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that protects all health information in the United States; instead, there is a patchwork of Laws that Providers must comply with. In general, most health care Providers are subject to various Laws and regulations pertaining to privacy of health information, including, without limitation, the following:

1. Federal Laws and Regulations
   - HIPAA
   - The Health Information Technology for Economic and Clinical Health Act (HITECH)
   - 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[1]. Disclosure of PHI by one covered entity to another covered entity, or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

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

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[1]See Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule
[2]See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

1. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:

   - Quality Improvement
   - Disease Management
   - Case Management and Care Coordination
   - Training Programs
   - Accreditation, Licensing, and Credentialing

Importantly, this allows Providers to share PHI with Molina 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**

   Patients may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.

3. **Requests for Confidential Communications**

   Patients may request that a health care Provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests by the patient.

4. **Requests for Patient Access to PHI**

   Patients have a right to access their own PHI within a Provider's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider includes the patient's medical record, as well as billing and other records used to make decisions about the Member's care or payment for care.

5. **Request to Amend PHI**

   Patients have a right to request that the Provider amend information in their designated record set.

6. **Request Accounting of PHI Disclosures**

   Patients may request an accounting of disclosures of PHI made by the Provider during the preceding six (6) year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations or made prior to April 14, 2003.

HIPAA Security

Providers must implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability and integrity of Molina Member and patient PHI. As more Providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate 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/NV for additional information regarding HIPAA standard transactions.

1. Click on the area titled "Provider Resources"
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 thirty (30) days and should also be reported to Molina within thirty (30) days of the change. Providers must use their NPI to identify it on all electronic transactions required under HIPAA and on all Claims and Encounters submitted to Molina.

Additional requirements for delegated providers

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

Reimbursement for copies of PHI

Molina 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

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.

1. Information security and cybersecurity

NOTE: This section (Information Security and Cybersecurity) is only applicable to Providers who have been delegated by Molina to perform a health plan function(s), and in connection with such delegated functions.

1. **Definitions:**

   (a) "Molina Information" means any information: (i) provided by Molina to Provider; (ii) accessed by Provider or available to Provider on Molina's Information Systems; or (iii) any information with respect to Molina or any of its consumers developed by Provider or other third parties in Provider's possession, including without limitation any Molina Nonpublic Information.

   (b) "Cybersecurity Event" means any actual or reasonably suspected contamination, penetration, unauthorized access or acquisition, or other breach of confidentiality, data integrity or security compromise of a network or server resulting in the known or reasonably suspected accidental, unauthorized, or unlawful destruction, loss, alteration, use, disclosure of, or access to Molina Information. For clarity, a Breach or Security Incident as these terms are defined under HIPAA constitute a Cybersecurity Event for the purpose of this section. Unsuccessful security incidents, which 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, do not constitute a Cybersecurity Event under this definition so long as no such incident results in or is reasonably suspected to have resulted in unauthorized access, use, acquisition, or disclosure of Molina Information, or sustained interruption of service obligations to Molina.

(c) "HIPAA" means the Health Insurance Portability and Accountability Act, as may be amended from time to time.

(d) "HITECH" means the Health Information Technology for Economic and Clinical Health Act, as may be amended from time to time.

(e) "Industry Standards" mean as applicable, codes, guidance (from regulatory and advisory bodies, whether mandatory or not), international and national standards, relating to security of network and information systems and security breach and incident reporting requirements, all as amended or updated from time to time, and including but not limited to the current standards and benchmarks set forth and maintained by the following, in accordance with the latest revisions and/or amendments:

  i.   HIPAA and HITECH

  ii.   HITRUST Common Security Framework

  iii.   Center for Internet Security

  iv.   National Institute for Standards and Technology ("NIST") Special Publications 800.53 Rev.5 and 800.171 Rev. 1, or as currently revised

  v.   Federal Information Security Management Act ("FISMA")

  vi.   ISO/ IEC 27001

  vii.   Federal Risk and Authorization Management Program ("FedRamp")

  viii. NIST Special Publication 800-34 Revision 1 – "Contingency Planning Guide for Federal Information Systems."

  ix.   International Organization for Standardization (ISO) 22301 – "Societal security – Business continuity management systems – Requirements."

(f) "Information Systems" means all computer hardware, databases and data storage systems, computer, data, database and communications networks (other than the Internet), cloud platform, architecture interfaces and firewalls (whether for data, voice, video or other media access, transmission or reception) and other apparatus used to create, store, transmit, exchange or receive information in any form.

(g) "Multi-Factor Authentication" means authentication through verification of at least two of the following types of authentication factors: (1) knowledge factors, such as a password; (2) possession factors, such as a token or text message on a mobile phone; (3) inherence factors, such as a biometric characteristic; or (4) any other industry standard and commercially accepted authentication factors.

(h) "Nonpublic Information" includes:

  i.   Molina's proprietary and/or confidential information;

  ii.   Personally Identifiable Information as defined under applicable state data security laws, including, without, limitation, "nonpublic personal information," "personal data," "personally identifiable information," "personal information" or any other similar term as defined pursuant to any applicable law; and

  iii.   Protected Health Information as defined under HIPAA and HITECH.

2. Information Security and Cybersecurity Measures. Provider shall implement, and at all times maintain, appropriate administrative, technical, and physical measures to protect and secure the Information Systems, as well as Nonpublic Information stored thereon, and Molina Information that are accessible to, or held by, Provider. Such measures shall conform to generally recognized industry standards and best practices and shall comply with applicable privacy and data security laws, including implementing and maintaining administrative, technical, and physical safeguards pursuant to HIPAA, HITECH, and other applicable U.S. federal, state, and local laws.

(a) Policies, Procedures, and Practices. Provider must have policies, procedures and practices that address its information security and cybersecurity measures, safeguards, and standards, including as applicable, a written information security program, which Molina shall be permitted to audit via written request, and which shall include at least the following:

   i. Access Controls. Access controls, including Multi-Factor Authentication, to limit access to the Information Systems and Molina Information accessible to or held by Provider.

   ii. Encryption. Use of encryption to protect Molina Information, in transit and at rest, accessible to or held by Provider.

   iii. Security. Safeguarding the security of the Information Systems and Molina Information accessible to or held by Provider, which shall include hardware and software protections such as network firewall provisioning, intrusion and threat detection controls designed to protect against malicious code and/or activity, regular (three or more annually) third party vulnerability assessments, physical security controls, and personnel training programs that include phishing recognition and proper data management hygiene.

   iv. Software Maintenance. Software maintenance, support, updates, upgrades, third party software components and bug fixes such that the software is, and remains, secure from vulnerabilities in accordance with the applicable Industry Standards.

(b) Technical Standards. Provider shall comply with the following requirements and technical standards related to network and data security:

   i. Network Security. Network security shall conform to generally recognized industry standards and best practices. Generally recognized industry standards include, but are not limited to, the applicable Industry Standards.

   ii. Cloud Services Security: If Provider employs cloud technologies, including infrastructure as a service (IaaS), software as a service (SaaS) or platform as a service (PaaS), for any services, Provider shall adopt a "zero-trust architecture" satisfying the requirements described in NIST 800-207 (or any successor cybersecurity framework thereof).

iii.   <u>Data Storage</u>. Provider agrees that any and all Molina Information will be stored, processed, and maintained solely on designated target servers or cloud resources. No Molina Information at any time will be processed on or transferred to any portable or laptop computing device or any portable storage medium, unless that device or storage medium is in use as part of the Provider's designated backup and recovery processes and is encrypted in accordance with the requirements set forth herein.

iv.   <u>Data Encryption</u>. Provider agrees to store all Molina Information as part of its designated backup and recovery processes in encrypted form, using a commercially supported encryption solution. Provider further agrees that any and all Molina Information, stored on any portable or laptop computing device or any portable storage medium be likewise encrypted. Encryption solutions will be deployed with no less than a 128-bit key for symmetric encryption, a 1024 (or larger) bit key length for asymmetric encryption, and the Federal Information Processing Standard Publication 140-2 ("FIPS PUB 140-2").

v.   <u>Data Transmissio</u>n. Provider agrees that any and all electronic transmission or exchange of system and application data with Molina and/or any other parties expressly designated by Molina shall take place via secure means (using HTTPS or SFTP or equivalent) and solely in accordance with FIPS PUB 140-2 and the Data Re-Use requirements set forth herein.

vi.   <u>Data Re-Use</u>. Provider agrees that any and all Molina Information exchanged shall be used expressly and solely for the purposes enumerated in the Provider Agreement and this section. Data shall not be distributed, repurposed, or shared across other applications, environments, or business units of Provider. Provider further agrees that no Molina Information or data of any kind shall be transmitted, exchanged, or otherwise passed to other affiliates, contractors or interested parties, except on a case-by-case basis as specifically agreed to in advance and in writing by Molina.

3.   <u>Business Continuity ("BC") and Disaster Recovery ("DR")</u>. Provider shall have documented procedures in place to ensure continuity of Provider's business operations, including disaster recovery, in the event of an incident that has the potential to impact, degrade, or disrupt Provider's delivery of services to Molina.

(a) "<u>Resilience Questionnaire</u>. Provider shall complete a questionnaire provided by Molina to establish Provider's resilience capabilities.

(b) "<u>BC/DR Plan.</u>

i.   Provider's procedures addressing continuity of business operations, including disaster recovery, shall be collected and/or summarized in a documented BC and DR plan or plans in written format ("BC/DR Plan"). The BC/DR Plan shall identify the service level agreement(s) established between Provider and Molina. The BC/ DR Plan shall include the following:

a)   Notification, escalation and declaration procedures.

b)   Roles, responsibilities and contact lists.

c)   All Information Systems that support services provided to Molina.

d)   Detailed recovery procedures in the event of the loss of people, processes, technology and/or third-parties or any combination thereof providing services to Molina within appropriate Recovery Time Objectives (RTOs) for the respective business processes and system components.

Protection Services Operations Center (PSOC) c/o Chief Information Security Officer Telephone: (844) 821-1942
Email: Cyberincidentreporting@molinahealthcare.com Molina's Protection Services Operations shall be provided to: Telephone: (866) 916-0918
Email: psoc@molinahealthcare.com

The Provider will notify Molina of a disruption to the services or activation of business continuity plans within two hours of occurrence 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 an appropriate Business Continuity Plans in place to prevent significant disruption to the services.

e)   BC and DR Testing. For services provided to Molina, Provider shall exercise its BC/DR Plan at least once each calendar year. Provider shall exercise its cybersecurity recovery procedures at least once each calendar year. At the conclusion of the exercise, Provider shall provide Molina a written report in electronic format upon request. At a minimum, the written report shall include the date of the test(s), objectives, participants, a description of activities performed, results of the activities, corrective actions identified, and modifications to plans based on results of the exercise(s).

4.   Cybersecurity Events.

(a) Provider agrees to comply with all applicable data protection and privacy laws and regulations. Provider will implement best practices for incident management to identify, contain, respond to, and resolve Cybersecurity Events.

(b) In the event of a Cybersecurity Event that threatens or affects Molina's Information Systems (in connection with Provider having access to such Information Systems); Provider's Information Systems; or Molina Information accessible to or held by Provider, Provider shall notify Molina's Chief Information Security Officer of such event by telephone and email as provided below (with follow-up notice by mail) as promptly as possible, but in no event later than twenty-four (24) hours from Provider's discovery of the Cybersecurity Event.

i.   In the event that Provider makes a ransom or extortion payment in connection with a Cybersecurity Event that involves or may involve Molina Information, Provider shall notify Molina's Chief Information Security Officer (by telephone and email, with follow-up notice by mail) within twenty-four (24) hours following such payment.

ii. Within fifteen (15) days of such a ransom payment that involves or may involve Molina Information, Provider shall provide a written description of the reasons for which the payment was made, a description of alternatives to payment considered, a description of due diligence undertaken to find alternatives to payment, and evidence of all due diligence and sanctions checks performed in compliance with applicable rules and regulations, including those of the Office of Foreign Assets Control.

(c) Notification to Molina's Chief Information Security Officer shall be provided to:

Molina Chief Information Security Officer
Telephone: (844) 821-1942
Email: CyberIncidentReporting@MolinaHealthcare.com

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

(d) In the event of a Cybersecurity Event, Provider will, at Molina's request, (i) fully cooperate with any investigation concerning the Cybersecurity Event by Molina, (ii) fully cooperate with Molina to comply with applicable law concerning the Cybersecurity Event, including any notification to consumers, and (iii) be liable for any expenses associated with the Cybersecurity Event including without limitation: (a) the cost of any required legal compliance (e.g., notices required by applicable law), and (b) the cost of providing two (2) years of credit monitoring services or other assistance to affected consumers. In no event will Provider serve any notice of or otherwise publicize a Cybersecurity Event involving Molina Information without the prior written consent of Molina.

(e) Following notification of a Cybersecurity Event, Provider must promptly provide Molina any documentation requested by Molina to complete an investigation, or, upon request by Molina, complete an investigation pursuant to the following requirements:

i. make a determination as to whether a Cybersecurity Event occurred;

ii. assess the nature and scope of the Cybersecurity Event;

iii. identify Molina 's Information that may have been involved in the Cybersecurity Event; and

iv. 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 Molina Information.

(f) Provider must provide Molina the following required information regarding a Cybersecurity Event 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 must include at least the following, to the extent known:

i. the date of the Cybersecurity Event;

ii. a description of how the information was exposed, lost, stolen, or breached;

iii. how the Cybersecurity Event was discovered;

iv. whether any lost, stolen, or breached information has been recovered and if so, how this was done;

v. the identity of the source of the Cybersecurity Event;

vi. 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;

vii. a description of the specific types of information accessed or 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;

viii. the period during which the Information System was compromised by the Cybersecurity Event;

ix. the number of total consumers in each State affected by the Cybersecurity Event;

x. 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;

xi. a description of efforts being undertaken to remediate the situation which permitted the Cybersecurity Event to occur;

xii. a copy of Provider's privacy policy and a statement outlining the steps Provider will take to investigate and if requested by Molina, the steps that Provider will take to notify consumers affected by the Cybersecurity Event; and

xiii. the name of a contact person who is familiar with the Cybersecurity Event and authorized to act on behalf of Provider.

(g) 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 Molina's request.

5. Right to Conduct Assessments; Provider Warranty. Provider agrees to fully cooperate with any security risk assessments performed by Molina and/or any designated representative or vendor of Molina. Provider agrees to promptly provide accurate and complete information with respect to such security risk assessments. If Molina performs a due diligence/security risk assessment of Provider, Provider (i) warrants that the services provided pursuant to the Provider Agreement will be in compliance with generally recognized industry standards and as provided in Provider's response to Molina's due diligence/security risk assessment questionnaire; (ii) agrees to inform Molina promptly of any material variation in operations from what was provided in Provider's response to Molina's due diligence/security risk assessment; and (iii) agrees that any material deficiency in operations from those as described in the Provider's response to Molina's due diligence/security risk assessment questionnaire may be deemed a material breach of the Provider Agreement.

6. Other Provisions. Provider acknowledges that there may be other information security and data protection requirements applicable to Provider in the performance of services which may be addressed in an agreement between Molina and Provider but are not contained in this section.

7. Conflicting Provisions. In the event of any conflict between the provisions of this section and any other agreement between Molina and Provider, the stricter of the conflicting provisions will control.

12. Claims and compensation

Payor ID	MLNNV (for all claims except EVV claims)
	NVMOL (for all EVV claims)
Availity	https://provider.MolinaHealthcare.com/
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 to reach Molina faster.

Molina offers the following electronic Claims submission options:
- Submit Claims directly to Molina via the Availity portal
- Submit Claims to Molina via your regular EDI clearinghouse

Availity

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

- Submit Professional (CMS-1500) and Institutional (CMS-1450 [UB04]) Claims with attached files
- Correct/Void Claims
- Add attachments to previously submitted Claims
- Check Claim 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.

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

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

When your Claims are filed via a Clearinghouse:

- You should receive a 999 acknowledgement from your clearinghouse.
- You should also receive 277CA response file with initial status of the Claims from your clearinghouse.
- You should refer to the Molina Companion Guide for information on the response format and messages.
- You should contact your local clearinghouse representative if you experience any problems with your transmission.

HIPAA 5010 Transaction Compliance Standards Implementation

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

EDI Claim submission issues

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

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 or when third-party insurance exists 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 though a clearinghouse or the Availity 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.

National Provider Identifier (NPI)

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

Required elements

Electronic submitters should use the Implementation Guide and Molina Companion Guide for format and code set information when submitting or receiving files directly with Molina. In addition to the Implementation Guide and Companion Guide, electronic submitters should use the appropriate state specific Companion Guides and Provider Manuals.

These documents are subject to change as new information is available. Please check the Molina website under EDI>Companion Guides for regularly updated information regarding Molina's companion guide requirements. Be sure to choose the appropriate State from the drop-down list on the top of the page. In addition to the Molina Companion Guide, it is also necessary to use the State Health Plan specific companion guides, which are also available on our Molina website for your convenience (remember to choose the appropriate state from the drop-down list).

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

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

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

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

CMS-1500

CMS 1500 Field #	NV Billing Requirement	CMS 1500 Field Name and Instructions
1	Not Required	**Type of health insurance coverage:** Check only the type of health coverage applicable to the claim. This field indicated the payer to whom the claim is being filed. Enter "X" in the box noted "Other."
1a	Required	**Insured ID Number:** identification number on the Member's Health Plan I.D. Card
2	Required	**Patient's Name:** Enter the patient's name as it appears on the Member's Health Plan I.D. card. Do not use nicknames
3	Required	**Patient's Birth Date, Sex:** 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	**Insured's Name:** Enter the patient's name as it appears on the member's Health Plan I.D. Card
5	Recommended	**Patient's Address, City, State, Zip Code, Telephone**
6	Recommended	**Patient relationship to insured**
7	Recommended	**Insured's Address, City, State, Zip Code, Telephone**
8	Not Required	**This field is reserved for NUCC use**
9	Recommended	**Other insured name:** 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	**Other insured 's policy or group Number:** 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	**This field is reserved for NUCC use**
9c	Not Required	**This field is reserved for NUCC use**
9d	Situational	**Insurance plan name or program name:** 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	**Is Patient's condition related to:** 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	**Reserved for local use**
11	Situational	**Insured's policy group or FECA number**
11a	Situational	**Insured's date of birth, sex**

CMS 1500 Field #	NV Billing Requirement	CMS 1500 Field Name and Instructions
11b	Situational	**Other Claim ID (Designated by NUCC)**
11c	Situational	**Insurance plan name or program name**
11d	Situational	**OR WORKERS' COMPENSATION OR PROPERTY & CASUALTY:** Required if known. Enter the claim number assigned by the payer
12	Not Required	**Patient's or authorized person's signature**
13	Not Required	**Insured's or authorized person's signature**
14	Situational	**Date of current illness, injury, or pregnancy:** 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	**If patient has had same or similar illness**
16	Situational	**Dates patient unable to work in current occupational**
17	Situational	**Name of referring Provider**
17a	Not Required	**Not Labeled**
17b	Situational	**NPI of Referring Provider**
18	Situational	**Hospitalization dates related to current services**
19	Situational	**Additional Claim Information (Designated by NUCC)**
20	Not Required	
21	Required	**Diagnosis or nature of illness or injury:** 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	**Resubmission Code:** 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 original claim number 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	**Prior authorization number:** 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.

CMS 1500 Field #	NV Billing Requirement	CMS 1500 Field Name and Instructions
24a	Required	**Dates of Service:** Dates: 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 is this field. For more information and examples on billing physician administered drugs, see the NDC Billing Reference on the Nevada Medicaid website.
24b	Required	**Place of Service:** Use the most appropriate Place of Service code in the bottom, white half of the claim line
24c	Not Required	**EMG:** Enter Y (Yes) or N (No) to indicate if the service was an emergency.
24d	Required	**Procedures, services or supplies CPT/HCPCS modifier:** CPT/HCPCS Code: 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.

CMS 1500 Field #	NV Billing Requirement	CMS 1500 Field Name and Instructions
24e	Required	**Diagnosis Pointer** 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	**Charges** 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	**Dates or units** Enter quantity (days, visits, units). If only one service provided, enter a numeric value of one
24h	Situational	**EPSDT/Family** Plan Leave blank or enter "Y" if the services were performed as a result of an EPSDT referral.
24i	Required	**ID Qualifier:** Using NPI field in field 24j: Enter ZZ in the top, shaded half of claim line
24j	Required	**Rendering Provider ID:** 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	**Federal Tax ID Number**
26	Recommended	**Patient's account number**
27	Situational	**Accept Assignment**
28	Required	**Total charge** Add all amounts in column 24F. Enter the total in this field.
29	Situational	**Amount Paid**
30	Situational	**Balance Due** (Reserved for NUCC Use)
31	Required	**Signature of physician or supplier:** The billing Provider or authorized representative must sign and date this field. Original, rubber stamp and electronic signatures are accepted.

CMS 1500 Field #	NV Billing Requirement	CMS 1500 Field Name and Instructions
32	Situational	**Service Facility Location Information:** 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	**NPI #** Enter the 10-character NPI ID of the facility where services were rendered.
32b	Not Required	**Other ID #**
33	Required	**Billing Provider Info & Ph #**: Enter the full address of the billing Provider.

CMS-1450 (UB-04)

Fields Marked with an Asterisk: In the Field column of the table below, some field numbers are preceded with an asterisk (*). In these fields, use HIPAA-compliant codes that are current for the date(s) of service on the claim.

UB 04 Field #	NV Billing Requirement	UB 04 Field Name and Instructions
1	Required	**Billing Provider name and address**
2	Not Required	**Pay-to name and address (unlabeled on form)**
3a	Recommended	**Patient control number:** 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	**Medical/Health record number**
*4	Required	**Type of Bill:** 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	**Federal Tax Number**
6	Required	**Statement covers period**: 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	**Reserved for assignment by the NUBC**
8a	Not Required	**Patient name identifier**

UB 04 Field #	NV Billing Requirement	UB 04 Field Name and Instructions Patient's
8b	Required	**Name:** Enter the patient's last name, first name, and middle initial as it appears on the Health Plan ID card**.**
9a-e	Not Required	**Patient's Address**
10	Not Required	**Patient's Date of Birth**
11	Not Required	**Patient sex**
12	Required	**Admission/start of care date**: Enter the date of admission for inpatient claims and date of service for outpatient claims.
*13	Recommended	**Admission hour (if applicable):** 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	**Priority (type) of visit:** Indicate the priority of the admission/ visit 1. Emergency 2. Urgent 3. Elective 4. Newborn 5. Trauma
*15	Required	**Source of referral for admission or visit:** Indicate the source of referral for this admission or visit.
*16	Situational	**Discharge Hour (if applicable):** If inpatient, indicate the hour in which the recipient was discharged from inpatient care. If outpatient, enter the hour the episode of care concluded.

UB 04 Field #	NV Billing Requirement	UB 04 Field Name and Instructions
*17	Required	**Patient discharge status:** 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.

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 Discharged/ transferred to a critical access hospital (CAH)

UB 04 Field #	NV Billing Requirement	UB 04 Field Name and Instructions
*18-28	Situational	**Condition Codes:** If applicable, indicate conditions or events relating to this claim.
29	Situational	**Accident State**
30	Not Required	**Reserved for assignment by the NUBC**
*31-34	Situational	**Occurrence codes and dates:** REQUIRED when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing
*35-36	Situational	**Occurrence span codes and dates:** REQUIRED when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing.
37	Not Required	**Reserved for assignment by the NUBC**
38	Not Required	**Responsible party name and address:**
*39-41	Situational	**Value codes and amounts:** REQUIRED when applicable. Value codes are used to identify events relating to the bill that may affect payer processing.
*42	Required	**Revenue Code:** Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient.

UB 04 Field #	NV Billing Requirement	UB 04 Field Name and Instructions
*43	Situational	**Description:** 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:

− 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 NDC and NDC quantity is this field. For more information and examples on billing outpatient facility administered drugs, see the NDC Billing Reference on the Hewlett Packard Enterprise website. |
| *44 | Situational | **HCPCS/Accommodation Rates/HIPPS Rate Codes:** Outpatient services: Enter the appropriate procedure code (HCPCS or CPT) |
| 45 | Situational | **Service Date:** 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 |

UB 04 Field #	NV Billing Requirement	UB 04 Field Name and Instructions
46	Required	**Service Units:** 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	**Total Charges:** Enter the total charge for each service line.
48	Recommended	**Non-covered charges:** 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 amount**s.**
49	Not Required	**Reserved for assignment by the NUBC**
50a-c	Line a Required Lines b & c Situational	**Payer Name** 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	**Health Plan ID**
52a-c	Required	**Release of Information Certification Indicator (REL INFO):** 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	**Assignment of benefits certification indicator (ASG BEN):** 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	**Prior payments:** Enter the amount received from the primary payer on the appropriate line
55a-c	Line a Required Lines b & c Situational	**Estimated amount due**
56	Required	**National Provider Identifier - Billing Provider (NPI):** Enter Provider's 10- character NPI ID

UB 04 Field #	NV Billing Requirement	UB 04 Field Name and Instructions
57a-c	Not Required	**Other (Billing) Provider identifier**
58a-c	Required	**Insured's Name:** 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	**Patient's Relationship to Insured**
60a-c	Line a Required Lines b & c Situational	**Insured's unique identifier:** 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	**Insured's group name**
62a-c	Recommended	**Insured's group number**
63a-c	Situational	**Treatment authorization code**
64a-c	Situational	**Document control number:** 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	**Employer name (Of the insured)**
66	Not Required	**Diagnosis and procedure code qualifier (ICD Version Indicator)**
67	Required	**Principal Diagnosis code and Present on Admission Indicator:** Enter the diagnosis code for the recipient's primary condition.
67a-q	Situational	**Other diagnosis codes:** 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	**Reserved for assignment by the NUBC**
69	Situational	**Admitting diagnosis code:** Enter the diagnosis code describing the recipient's reason for admission. This is required on inpatient claims only

UB 04 Field #	NV Billing Requirement	UB 04 Field Name and Instructions
70a-c	Situational	**Patient's reason for visit:** 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	**Prospective Payment System (PPS) Code**
72a-c	Situational	**External Cause of Injury (ECI) code**
73	Not Required	**Reserved for assignment by the NUBC**
74	Situational	**Principal Procedure Code and Date:** Enter the ICD-9/10 Procedure Code that identifies the principal/primary procedure performed.
74a-e	Situational	**Other procedure codes and dates:** 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 in-patient claims when additional procedures must be reported (not required on an outpatient claim).
75	Situational	**Adjust or void a claim**
76	Recommended	**Attending Provider name and identifiers:** Enter servicing (rendering) Provider's NPI.
77	Situational	**Operating physician name and identifiers:** 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	**Other:** Enter the NPI of the ordering, prescribing, or referring Provider, if applicable.
79	Not Required	**Other Provider name and identifiers**
80	Not Required	**Remarks field**
81a-d	Situational	**Code-code field:** Use this field to report additional value codes and/or taxonomy codes if applicable.

EDI (Clearinghouse) Submission

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

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

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

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

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

Paper Claim submission

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

When submitting paper Claims:

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

Corrected Claim Process

Providers may correct any necessary field of the CMS-1500 and CMS-1450 (UB-04) forms.

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

All Corrected Claims:

- Must be free of handwritten or stamped verbiage (paper Claims).
- Must be submitted on a standard red and white CMS-1450 (UB-04) or CMS-1500 Claim form (paper Claims).
- Original Claim number must be inserted in field 64 of the CMS-1450 (UB-04) or field 22 of the CMS-1500 of the paper Claim, or the applicable 837 transaction loop for submitting corrected claims electronically.
- The appropriate frequency code/resubmission code must also be billed in field 4 of the CMS-1450 (UB-04) and 22 of the CMS-1500.

  Note: The frequency/resubmission codes can be found in the NUCC (National Uniform Claim Committee) manual for CMS-1500 Claim forms or the UB Editor (Uniform Billing Editor) for CMS-1450 (UB-04) Claim forms.

Corrected Claims must be sent within 180 calendar days from the last date of service, 365 calendar days from the last date of service for non-contracted providers.

Corrected Claims submission options:

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

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

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

Medicaid is always the payer of last resort and Providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Molina Members. If third-party liability can be established, Providers must bill the primary payer and submit a primary explanation of benefits (EOB) to Molina for the secondary Claim processing. In the event that coordination of benefits occurs, Provider shall be reimbursed based on the state regulatory COB methodology. Primary carrier payment information is required with the Claim submission. Providers can submit Claims with attachments, including EOB and other required documents. Molina will pay claims for prenatal care and preventive pediatric care (EPSDT) and then seek reimbursement from third parties. If services and payment have been rendered prior to establishing third-party liability, an overpayment notification letter will be sent to the Provider requesting a refund, including third-party policy information required or billing.

Subrogation - Molina retains the right to recover benefits paid for a Member's health care services when a third party is responsible for the Member's injury or illness to the extent permitted under State and Federal law and the Member's benefit plan. If third party liability is suspected or known, please refer pertinent case information to Molina's vendor, Optum, at submitreferrals@optum.com.

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."

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):

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

6. Other Injuries

   a) Manifestations of Poor Glycemic Control

   b) Hypoglycemic Coma
   c) Diabetic Ketoacidosis
   d) Non-Ketotic Hyperosmolar Coma
   e) Secondary Diabetes with Ketoacidosis
   f) 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.gov

Molina coding policies and payment policies

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

Reimbursement guidance and payment guidelines

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

- For diagnoses, the required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM:

- For procedures:
  - Professional and outpatient Claims require the Healthcare Common Procedure Coding System Level 1 (CPT codes), Level 2 and 3 (HCPCS codes).
  - Inpatient hospital Claims require ICD-10-PCS (International Classification of Diseases, 10th Revision, Procedure Coding System).

Furthermore, Molina requires that all Claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

Molina utilizes a claims adjudication system that encompasses edits and audits that follow State and Federal requirements as well as administers payment rules based on generally accepted principles of correct coding. These payment rules include, but are not limited to, the following:

- Manuals and Relative Value Unit (RVU) files published by the Centers for Medicare & Medicaid Services (CMS), including:
  o 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.
  o In the absence of State guidance, Medicare National Coverage Determinations (NCD).
  o In the absence of State guidance, Medicare Local Coverage Determinations (LCD).
  o 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 in accordance with applicable billing guidelines. For guidance, please refer to the resources located at NV Medicaid MSM Chapter 3400-Telehealth and NV Medicaid Telehealth Billing Instructions.

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. 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.

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 (1) physician
- Unilateral procedure was performed
- Bilateral procedure was performed
- Service or procedure was provided more than once
- Only part of a service was performed

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

ICD-10-CM/PCS codes

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

Place of Service (POS) codes

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

Type of bill

Type of bill is a four-digit alphanumeric code that gives three specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care, also referred to as a "frequency" code. For a complete list of codes, reference the National Uniform Billing Committee's (NUBC) Official CMS-1450 (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 CMS-1450 (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 National Drug Code number (NDC) must be reported on all professional and outpatient Claims when submitted on the CMS-1500 Claim form, CMS-1450 (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 or by contacting our Provider Relations department.

Overpayments and incorrect payments refund requests

In accordance with 42 CFR 438.608, Molina requires network Providers to report to Molina when they have received an overpayment and to return the overpayment to Molina within sixty (60) calendar days after the date on which the overpayment was identified and notify Molina in writing of the reason for the overpayment.

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

- Submit a refund to satisfy overpayment,
- Submit request to offset from future claim payments.
- Dispute overpayment findings.

A copy of the overpayment request letter and details are available in the Availity portal. In the Overpayment Application section, Providers can make an inquiry, contest an overpayment with supporting documentation, resolve an overpayment, or check status. This is Molina's preferred method of communication.

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

Overpayments related to TPL/COB will contain primary insurer information necessary for rebilling including the policy number, effective date, term date, and subscriber information. For Members with Commercial COB, Molina will provide notice within 270 days from the Claim's paid date if the primary insurer is a Commercial plan. For Members with Medicare COB Molina will provide notice within 540 days from the Claim's paid date if the primary insurer is a Medicare plan. A Provider may resubmit the Claim with an attached primary EOB after submission to the primary payer for payment. Molina will adjudicate the Claim and pay or deny the claim in accordance with Claim processing guidelines.

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

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

Claim 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 can be found on the 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:

- [Availity](#) portal

- Submitted via fax: (833) 412-3146

- Mail at the following address:
  Nevada Member Appeals & Grievances
  PO Box 182273
  Chattanooga, TN 37422

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 ninety (90) calendar days from the date of Molina's resolution of the appeal.

Nevada Medicaid Hearings Unit
9850 Double R Blvd. Suite 200
Reno, NV 89521
Phone: (775) 684-3604
Fax: (775) 684-3610
Email: 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 Member for Covered Services is prohibited, except for the Member's applicable copayment, coinsurance, and deductible amounts.

Fraud, waste, and abuse

Failure to report instances of suspected fraud, waste, and abuse is a violation of the Law and subject to the penalties provided by Law. For additional information, please refer to the Compliance section of this Provider Manual.

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 sixty (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 fifteen (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 (2) types of responses:

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

13. Grievance and appeals process

If a Member is unhappy with anything about Molina 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.

Members have limited time to present documents about their case, in person or in writing. Reasonable assistance is available in completing forms and taking other procedural steps including assisting the Member and/or your authorized representative. Non-emergency transportation is available if the Member needs to bring documents in person through the state's transportation vendor, MTM. Members can call MTM at (844) 879-7341, TTY/TDD:711. 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 five (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 forty-five 45 calendar days (with a possible fourteen [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
Fax   : (833) 412-3146
Phone   : (833) 685-2102

Mail:

Nevada Member Appeals & Grievances
Molina Healthcare Inc.
PO Box 182273
Chattanooga, TN 37422

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 including for an expedited appeal. Molina will send an acknowledgement letter in twenty-four (24) hours for Expedited Appeals and five calendar days for Standard Appeals from the date of receipt as an acknowledgment of receipt of the appeal. Appeals must be submitted within sixty (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
Fax   : (833) 412-3145
Phone   : (833) 685-2102

Mail:
Nevada Member Appeals & Grievances
Molina Healthcare Inc.
PO Box 182273
Chattanooga, TN 37422

Expedited appeals

A Molina member, Provider acting on behalf of the member, or member's representative, may file an expedited appeal within sixty (60) calendar days from the date on the notice of determination. Molina reviews the appeal, and a final determination will be made within seventy-two (72) hours (with a possible fourteen [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 time frame of no longer than thirty (30) calendar days from the day the Plan receives the Appeal (with a possible fourteen [14] calendar day extension) for resolution of Appeal and give the member prompt oral notice of the denial and follow up within two (2) calendar days with a written notice. Members have the right to file a Grievance if the member disagrees with the decision to extend the time frame.

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 sixty (60) calendar days from the date on the notice of determination.

Molina reviews member appeals and provides a final determination within thirty (30) calendar days (with a possible fourteen [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:
    - o 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;
    - o The member files 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 of the following occurs:

- The member withdraws the appeal;
- calendar days have passed from the date of the notice of appeal resolution and the member has 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:

Nevada Member Appeals & Grievances
Molina Healthcare Inc.
PO Box 182273
Chattanooga, TN 37422

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 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 ninety (90) calendar days from the date of Molina's resolution of the appeal.

Nevada Medicaid Hearings Unit
9850 Double R Blvd. Suite 200
Reno, NV 89521
Phone: (775) 684-3604
Fax: (775) 684-3610
Email: dhcfphearings@dhcfp.nv.gov

Provider disputes
Provider grievances

Providers may file grievances at any time. Molina will investigate and provide final resolution within ninety (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

Mail:
Nevada Provider Appeals & Grievances
Molina Healthcare Inc.
PO Box 182273
Chattanooga, TN 37422

Claim appeals/disputes

For information on the Claim Appeals/Disputes process, please see the Claims Appeals/Disputes sub-section within the Claims and Compensation section of this Provider 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 and Health Equity Transformation 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 and Health Equity Transformation Committee for evaluation. If required by the state or CMS, reporting is submitted to the Appropriate Agency as needed.

Record Retention

Molina will retain records of all Provider Disputes for a minimum of ten (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 recredentialing

Network Development and Maintenance

Molina 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 follows DHCFP's access and availability requirements. All Providers who provide services to Molina Members agree to comply with all federal and state laws.

Molina 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 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 subspecialist for a Molina Member, please contact us at (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 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 and Recredentialing

The Credentialing Program assures that 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 Relations 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, recredentialing 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 does not 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 –** Practitioners 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 –** Practitioners 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 –** Practitioners must hold a current, valid, unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Practitioners must have a DEA or CDS in every State where the Practitioner provides care to Molina Members. If a Practitioner has a pending DEA/CDS certificate and never had any disciplinary action taken related to their DEA and/or CDS 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 –** Practitioners will only be credentialed in the specialty in which they have adequate education and training. Practitioners must confine their practice to their credentialed area of practice when providing services to Molina Members.

- **Education –** Practitioners must have graduated from an accredited school with a degree required to practice in their designated specialty.

- **Residency Training –** Practitioner must have satisfactorily completed a residency training from an accredited program in the specialty in which they are practicing. Molina only recognizes 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 –** Fellowship training is verified when a practitioner will be advertised in the directory in their fellowship specialty. Molina only recognizes fellowship programs accredited by ACGME, AOA, CFPC, and CODA.

- **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)

- o Behavioral Analyst Certification Board (BACB)
- o National Commission on Certification of Physician Assistants (NCCPA)

- **General Practitioners –** Practitioners who are not board certified and have not completed a training from an accredited 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 (5) 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), or as an Urgent Care or Wound Care Practitioner. General Practitioners providing only wound care services do not require five (5) 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 –** Practitioners must supply the most recent five-(5) 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 (6) months, the Practitioner must clarify the gap verbally or in writing. The organization documents a verbal clarification
  - o in the Practitioner's credentialing file. If the gap in employment exceeds one (1) year, the Practitioner must clarify the gap in writing.

- **Malpractice History –** Practitioners 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 –** Practitioners must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations, and non-renewals.
  - o Practitioner must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing, or failure to proceed with an application 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. At the time of initial application, the practitioner must not have any pending or open investigations from any State or governmental professional disciplinary body[3]. This would include Statement of Charges, Notice of Proposed Disciplinary Action, or the equivalent.

- **Medicare, Medicaid and other Sanctions and Exclusions –** Practitioners 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 –** Practitioners 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 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 –** Practitioners 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.

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

- **Lack of Present Illegal Drug Use –** Practitioners must disclose if they are currently using any illegal drugs/substances.
- **Criminal Convictions –** Practitioners must disclose if they have ever had any of the following:
    - Criminal convictions., including any convictions, guilty pleas, or 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 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, practitioners must not have any pending criminal charges in the categories listed above.

- **Loss or Limitations of Clinical Privileges –** At initial credentialing, Practitioners 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, practitioners 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 –** Practitioners 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 if 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 actions, sanctions, or exclusions. Molina is not required to reveal the source of information if the information is 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 ten (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 ten (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 appointment time to review their file and allow up to seven (7) 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 the 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 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.

Professional Review Committee (PRC)

Molina designates a PRC to make recommendations regarding credentialing decisions using a peer review process. Molina works with the PRC to assure that network Practitioners are competent and qualified to provide continuous quality care to Molina members. The PRC reports to the Quality Improvement Committee (QIC.) Molina utilizes information such as, but not limited to credentialing verifications, QOCs, and member complaints to determine continued participation in Molina's network or if any adverse actions will be taken. Certain PRC decisions may be appealed. To utilize this process, providers should request a fair hearing as outlined below and in Molina's policy. Please contact Molina Provider Relations representatives for additional information about fair hearings.

Notification of Credentialing Decisions

A letter is sent to every Practitioner 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 Practitioner'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.

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 Practitioner sanctions and exclusions between recredentialing cycles for all Practitioner types and takes appropriate action against Practitioners when instances of poor quality are identified. If a Molina Practitioner is found to be sanctioned or excluded, the Practitioner's contract will be immediately 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.
- **The OIG High Risk list –** Monitor for individuals or facilities who refused to enter into a Corporate Integrity Agreement (CIA) with the federal government on or after October 1, 2018.
- **State Medicaid Exclusions –** Monitor for State Medicaid exclusions through each state's specific Program Integrity Unit (or equivalent).
- **Medicare Exclusion Database (MED) –** Monitor 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 Practitioners sanctioned by SAM.

Molina also monitors the following for all Practitioner 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 Professional Review Committee suspends or terminates a Practitioner's contract based on quality of care or professional conduct, a certified letter is sent to the Practitioner describing the adverse action taken and the reason for the action, including notification to the Practitioner of the right to a fair hearing when required pursuant to Laws or regulations.

15. Delegation

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

a. Utilization Management
b. Credentialing and Recredentialing
c. Claims
d. Complex Case Management
e. CMS Preclusion List Monitoring
f. 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 for compliance with performance expectations 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.

Delegation criteria

An entity may request Credentialing, Utilization Management or Claims delegation from Molina through Molina's Delegation Oversight Director/Manager or through their Contract Manager. Molina will request a potential delegate to submit policies and procedures for review and will schedule a time for an onsite pre- assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate is based on the Medical Group, IPA, or Vendor's ability to meet Molina, State and Federal requirements for delegation of the function.

Sanction monitoring

All Delegates are required to have processes to screen staff and employees at all levels against Federal and State exclusion lists. Screening must be done prior to the employee/staff's hire date and occur monthly thereafter.

Molina will include a Sanction Monitoring pre-assessment audit with all other pre-assessment audits, any time a function(s) is/are being considered for delegation.

Sanction Monitoring functions may be delegated to entities that meet Molina criteria. To be delegated for sanction monitoring functions, potential delegates must at minimum:

- Pass Molina's sanction monitoring pre-assessment and annual audits, which are based on OIG standards.
- Demonstrate that employees and staff are screened against Office of Inspector General (OIG) and System for Award Management (SAM) sanction lists prior to hire dates, and monthly thereafter.
- Correct deficiencies within Molina approved timeframes when issues of non-compliance are self-reported by a delegated entity or identified by Molina.
- Agree to Molina's contract terms and conditions for sanction monitoring delegates.
- Submit timely and complete Sanction Monitoring delegation reports as detailed in the Delegated Services Addendum or as communicated by Molina to the applicable Molina contact.
- Comply with all applicable accreditation and regulatory standards and applicable Federal and State Laws.
- When staff or employees are identified as having a positive sanction, provide Molina with notification according to Contractual Agreements of the findings and action(s) being taken to ensure sanctioned staff is not providing services to Molina Members.
- Provide a ninety (90)-day advance notification to Molina of its intent to sub-delegate and include pre-delegation review/results and delegate oversight process.
- In a timely and appropriate manner, respond, cooperate, and participate when applicable, in Health Plan, legal and regulatory inquiries and audits.

Credentialing

Credentialing functions may be delegated to entities that meet National Committee for Quality Assurance (NCQA) criteria for credentialing functions.

To be delegated for credentialing functions, potential delegates must at minimum:

- Pass Molina's credentialing pre-assessment and annual audits, which are based on NCQA credentialing standards, contract requirements and state and federal regulatory requirements.
- Have a multi-disciplinary Credentialing Committee who is responsible for review and approval, or denial/termination of practitioners included in delegation.

- Have an ongoing monitoring process in place that screens all practitioners included in delegation against OIG and SAM, and exclusion lists a minimum of every thirty (30) days.

- Have internal controls and quality monitoring of work performed by Credentialing staff

- Correct deficiencies within Molina established timeframes when issues of non-compliance are identified by Molina or a state or federal regulatory agency.

- Agree to Molina's contract terms and conditions for credentialing delegates

- Submit timely and complete Credentialing delegation reports as detailed in the Delegated Services Addendum or as communicated by Molina to the applicable Molina contact.

- Comply with all applicable accreditation and regulatory standards and applicable Federal and State Laws.

- When key specialists, as defined by Molina, contracted with IPA or group terminate, provide Molina with a letter of termination according to Contractual Agreements and the information necessary to notify affected members.

- Provide a ninety (90)-day advance notification to MHC of its intent to sub-delegate and include pre- delegation review/results and delegate oversight process.

- In a timely and appropriate manner, respond, cooperate, and participate when applicable, in Health Plan, legal and regulatory inquiries and audits.

Note: At its discretion, Molina may conduct a modified pre-assessment audit if the Provider is an NCQA-certified or Accredited organization. Modification to the audit depends on the type of Certification or Accreditation the Medical Group, IPA, or Vendor has, but will always include evaluation of applicable state requirements and Molina business needs.

If the Provider sub-delegates Credentialing functions, the sub-delegate must be NCQA accredited or certified in Credentialing functions, or demonstrate an ability to meet all Health Plan, NCQA, and State and Federal requirements identified above. A written request must be made to Molina prior to execution of a contract, and a pre-assessment must be made on the potential sub-delegate, and annually thereafter. Evaluation should include review of Credentialing policies and procedures, Credentialing and recredentialing files, and a process to implement corrective action if issues of non-compliance are identified.

Utilization management

Utilization Management (UM) functions may be delegated to entities that meet National Committee for Quality Assurance (NCQA) criteria, regulatory and Molina established standards for utilization management functions and processes.

To be delegated for utilization management functions, potential delegates must at minimum:

- Pass Molina's Utilization Management pre-assessment and annual audits, which are based on regulatory, NCQA UM and Molina established standards and state and federal regulatory requirements.

- Have a multi-disciplinary Utilization Management Committee who is responsible for oversight of the UM program, review and approval of UM policies and procedures and ensuring compliance of the UM processes and decisions.

- Have a full time Medical Director responsible for the UM program and holds an unrestricted license to practice medicine in California.
- Have internal controls and quality monitoring of work performed by the UM staff.
- Correct deficiencies within Molina established timeframes when issues of non-compliance are self-identified, identified by Molina or a state or federal regulatory agency.
- Agree to and cooperate with Molina's contract terms and conditions for utilization management delegates.
- Submit timely and complete Utilization Management delegation reports in a format and frequency determined by Molina.
- Comply with all applicable accreditation and regulatory standards and applicable Federal and State Laws.
- Provide a ninety (90)-day advance notification to Molina of its intent to sub-delegate and include pre-delegation review/results and delegate oversight process.
- In a timely and appropriate manner, respond, cooperate, and participate when applicable, in Health Plan, legal and regulatory inquiries and audits.
- Comply with contractual, regulatory, and legal requirements for member and provider notification of utilization management decisions.
- Prohibit the use of verbal denials and other intangible methods of documenting physician review unless otherwise allowed by regulation or law.

Claims

Claims functions may be delegated to entities that demonstrate the ability to meet regulatory and Health Plan requirements for Claims functions. To be delegated for Claims functions, potential delegates must at a minimum:

- Pass Molina's Claims pre-assessment and annual audits, which are based on state and federal laws and regulatory and Molina-established standards.
- Have internal controls and quality monitoring of work performed by Claims staff.
- Correct deficiencies within Molina-established time frames when issues of non-compliance are identified by Molina or a state or federal regulatory agency.
- Agree to Molina's contract terms and conditions for Claims delegates.
- Submit timely and complete Claims delegation reports as detailed in the Delegated Services Addendum or as communicated by Molina to the applicable Molina contact.
- Comply with all regulatory standards and applicable Federal and State Laws
- Have systems enabled to accurately and timely adjudicate professional and facility claims, including but not limited to the appropriate application of interest penalties, edits, audit trail, fee schedule, provider contracting status, denial codes, payment codes, pend codes and accumulators.

- Provide a ninety (90)-day advance notification to Molina of its intent to sub-delegate and include pre-delegation review/results and delegate oversight process.
- In a timely and appropriate manner, respond, cooperate, and participate when applicable, in Health Plan, legal and regulatory inquiries and audits.

Oversight monitoring of delegated functions

Prior to approval of delegation, and at least annually thereafter, Molina conducts an onsite review of IPAs/Medical Groups requesting delegation. Molina uses delegation standards and practices in compliance with NCQA, State and Federal Requirements. A member or designee of the Delegation Oversight team assigned to evaluate and oversee the IPAs/Medical Groups activities conducts the audit. Based on the audit scores and findings, if required thresholds and criteria are met, the appropriate Committee may approve specific delegation of functions to the IPA/Medical Group to perform. Once approved for delegation, an "Acknowledgement Acceptance of Delegation" must be signed between Molina and the IPA/Medical Group. For delegation of utilization management, a "Delineation of Utilization Management Responsibilities" grid is included with the Acknowledgement and Acceptance of Delegation", outlining the delegated activities; Molina's Responsibilities; the Delegated IPA/Medical Group Responsibilities; the Frequency of Reporting; Molina's Process for Evaluating Performance; and Corrective Actions if the IPA/Medical Group fails to meet its responsibilities. Ad-hoc audits may be conducted at the discretion of the Health Plan.

Molina reserves the right to request corrective action plans, sanction or revoke the delegation of these responsibilities when the Delegated group demonstrates noncompliance to NCQA, contractual, State and Federal Requirements.

Delegates must comply with all applicable State and federal laws and regulations, contract requirements, and other DHCS guidance, including All Plan Letters (APLs) and Policy Letters.

Complex Case Management services are not delegated to IPAs/Medical Groups. IPAs/Medical Groups are required to refer known or potential cases to MHC Case Management. The referral may be made by a telephone or facsimile. This information can also be found in the Medical Management Section and in the Public Health Coordination and Case Management.

Member confidential communication

To the extent applicable to the function delegated, the Delegated Entity shall comply with the requirements of California Civil Code Section 56.107, and any other similar laws, which provide Members with the right to confidential communications, including confidential communications with respect to certain sensitive services ("Confidential Communications"). The Delegated Entity shall comply with any direction by Molina with respect to Confidential Communications with a designated Member. If the Delegated Entity handles delivery or transmission of Confidential Communications, responding to a Member's request for Confidential Communications, or other services involving Confidential Communications, the Delegated Entity shall comply with Molina's policies, procedures, manuals, and instructions regarding Confidential Communications including, but not limited to the following requirements:

- Delegated Entity shall not require a protected individual to obtain the Subscriber's, or other Member's authorization to receive sensitive services or to submit a claim for sensitive services if the protected individual has the right to consent to care.
- Delegated Entity shall recognize the right of a protected individual to exclusively exercise rights granted under the California Confidentiality of Medical Information Act regarding medical information related to sensitive services that the protected individual has received.
- Delegated Entity shall direct all communications regarding a protected individual's receipt of sensitive services directly to the protected individual receiving care as follows:
    - If the protected individual has designated an alternative mailing address, email address, or telephone number pursuant to a Confidential Communications request, Delegated Entity shall send or make all communications related to the protected individual's receipt of sensitive services to the alternative mailing address, email address, or telephone number designated.
- If the protected individual has not designated an alternative mailing address, email address, or telephone number pursuant to a Confidential Communications request, the Delegated Entity shall send or make all communications related to the protected individual's receipt of sensitive services in the name of the protected individual at the address or telephone number on file.
- Communications subject to confidential communication requirements include the following written, verbal, or electronic communications related to the receipt of sensitive services:
    i. Bills and attempts to collect payment.
    ii. A notice of adverse benefits determinations.
    iii. An explanation of benefits notice.
    iv. A Delegated Entity's request for additional information regarding a claim.
    v. A notice of a contested claim.
    vi. The name and address of a provider, description of services provided, and other information related to a visit.
    vii. Any written, oral, or electronic communication from a Delegated Entity that contains protected health information.
- Delegated Entity shall not disclose medical information related to sensitive health care services provided to a protected individual to the Subscriber or any Molina Members other than the protected individual receiving care, absent an express written authorization of the protected individual receiving care.

Molina reserves the right to audit the delegated entity's operations to confirm compliance with the requirements contained herein.

16. Pharmacy

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 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, 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 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 three (3) year 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/NV or calling Molina at (833) 685-2103.

Drug formulary

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. The pharmacy program does not cover all medications. For a complete list of covered medications please visit MolinaHealthcare.com/NV.

Information on procedures to obtain these medications is described within this document and also available on the Molina website at MolinaHealthcare.com/NV.

Formulary medications

Formulary medications with PA may require the use of first-line medications before they are approved. Information on procedures to obtain these medications is described within this document and is also available on the Molina website at MolinaHealthcare.com/NV.

Quantity limitations

In some cases, Members may only be able to receive certain quantities of medication. Information on specific limits can be found in the formulary document. 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 at Provider Forms. 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 preferred. If the use of a particular brand name non- preferred drug 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 (6) months on the market. During this period, access to these medications will be considered through the PA process.

Medications not covered

There are some medications that are excluded from coverage. For example, drugs used in the treatment of fertility or those used for cosmetic purposes may not be part of the benefit. For a complete list of drugs excluded from the plan benefit please refer to the Member's Specific exclusions can be found in the formulary at MolinaHealthcare.com/NV

Prescription discount Cards

Applying prescription discount cards and related programs is prohibited when submitting claims to Nevada Medicaid. Prescription discount cards and related programs may not be combined with Nevada Medicaid prescription coverage or included as part of any claim submission to Nevada Medicaid. Providers will be responsible for the full claim amount and not eligible for reimbursement for claims submitted in combination with or including a prescription discount card.

Submitting a Prior Authorization request

Molina will only process completed PA request forms at Provider Forms, the following information MUST be included for the request form to be considered complete:

- Member first name, last Name, date of birth and identification number
- Prescriber first name, last name, NPI, phone 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/NV 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 electronic medical Claim submission.

Molina 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.

Molina completes Utilization Management for certain Healthcare Administered Drugs. For any drugs on the prior authorization list that use a temporary C code or other temporary HCPCS code that is not unique to a specific drug, which are later assigned a new HCPCS code, will still require prior authorization for such drug even after it has been assigned a new HCPCS code, until otherwise noted in the Prior Authorization list.

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/NV under the Health Resource tab. Please consult with your Provider Relations representative or reference the medication formulary for more information on Molina's Pain Safety Initiatives.

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