2018
Provider Manual

Centennial Care

2018 Provider Manual, Version 2 – Reimbursement Guidance, pages 199, 200
Molina Healthcare of New Mexico, Inc.

Thank you for being a partner with Molina Healthcare of New Mexico!

Dear Practitioner/Provider:

Thank you for your active participation in the delivery of quality healthcare services to Molina Healthcare of New Mexico, Inc. (Molina Healthcare) Members.

The Provider Manual was designed to provide you with assistance in understanding Molina Healthcare's program, processes, and policies as they pertain to all areas of your practice. This manual may be revised as Molina Healthcare's policies, program or regulatory requirements change. All changes and revisions will be updated and posted to the Molina Healthcare website located at www.molinahealthcare.com as they occur.

Contracted practitioners and organizational providers are an essential component in helping Molina Healthcare deliver quality care to our Members. We deeply value our partnership with you, and appreciate the compassionate delivery of care you provide to our Members. As our partner, assisting you in understanding Molina Healthcare better, is one of our highest priorities. We welcome your feedback and support your efforts to provide quality care.

Sincerely,

Provider Services
Molina Healthcare of New Mexico, Inc.

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Section 1 – Background and Overview of Molina Healthcare, Inc.

Introduction to Centennial Care

This manual serves as a guide for providing covered services to Molina Healthcare Members enrolled in Centennial Care. The cornerstone of this program is a, comprehensive network, delivering medical, behavioral, and long-term support services (LTSS), with an emphasis on Member care coordination. This ensures that Member's receive the right care, in the right place, at the right time, ensuring better health outcomes. Quality care and improved health outcomes are determined by:

- Assessing each Member's physical, behavioral, functional, and psychosocial needs;
- Identifying the medical, behavioral, or LTSS provider;
- Ensuring timely access to care, and provision, coordination, and monitoring of services necessary to help each Member maintain or improve physical and/or behavioral health status; and
- Facilitating Member access to other social support services, and assistance needed to promote Members health, safety, and welfare.

Molina Healthcare updates and publishes its Provider Manual once a year. All contracted practitioners or organizational providers (Provider or Providers) will be notified of any additional updates or changes that occur via the Provider Newsletter or by letter. To receive a printed version of the Molina Healthcare Provider Manual, please contact your Provider Services Representative at (505) 342-4660, toll free at (800) 377-9594.

This manual is supplemented by the following additional Provider Reference Manuals:
Molina Medicare - Molina Medicare Provider Manual
Molina Healthcare Marketplace - Molina Healthcare Marketplace Provider Manual

Company Profile

Molina Healthcare, Inc. (MHI) is headquartered in Long Beach, California. Founded more than thirty years ago, MHI has grown to serve approximately 5 million Members across the nation.

MHI and its affiliated health plans, focus on providing healthcare services to people who receive benefits through government-sponsored programs such as Medicaid and Medicare. MHI strives to break down the financial, cultural and linguistic barriers that prevent low-income families and individuals from accessing appropriate healthcare – and does so by collaborating with state and federal government programs. MHI is an exceptional health care organization, emphasizing on improving access to quality care, increasing care coordination, and improving health outcomes for Members; while cultivating a culturally sensitive, and provider-friendly environment.

C. David Molina, M.D., founded Molina in 1980 as a healthcare delivery system encompassing a network of primary care clinics in California. As the need for effective patient management and delivery of healthcare services to underserved populations continued to grow, MHI

became licensed as a Health Maintenance Organization (HMO) in California.

Dr. Molina believed that people should be treated like family, and that every person deserves affordable quality health care. Molina is devoted to its mission and vision of providing quality health care to people receiving government assistance.

MHI is committed to quality and has made achieving accreditation a strategic goal for each of its health plans. Year after year, Molina health plans have successfully received accreditation from the National Committee for Quality Assurance (NCQA). The NCQA accreditation process sets the industry standard for quality in health plan operations.

Network Management and Operations Department

The Network Management and Operations Department (NM&O) is devoted exclusively to the needs of contracted providers.

- **Provider Contracting.**
  The staff in this area builds the contracted network by negotiating agreements with practitioners and organizational providers in New Mexico primarily, bordering states, and across the nation. Contracting works with providers to help them understand both their contract language terms and reimbursement fee schedules. They may also amend agreements as needed due to regulatory or program requirements. This department also provides geo-access analysis reporting to ensure Members have access to an adequate network of providers of all specialties.
- **Provider Inquiry, Research and Resolution (PIRR).**
  PIRR addresses provider inquiries, research and resolution.
- Provider Reconsideration Review (PRR) addresses provider reconsiderations, appeals, grievances and the reconsideration processes regarding claims payments and/or denials.
- **Member Advocacy - Grievances, Appeals and Fair Hearings (MIRR).**
  MIRR helps Members resolve their health plan concerns and disagreements with coverage decisions
- **Provider Services.**
  This area has dedicated Provider Service Representatives (PSRs) to conduct visits to provider offices, provide training, answer questions and serve as the plan point of contact for all provider needs. The PSR Territory Map depicts the plan service areas, and the PSR responsible for each of the geographic areas. The r contact information for individual PSRs may be found in the "Contact Information for Providers" section below.
- **Provider Credentialing & Delegation.**
  The primary responsibility of the Credentialing and Delegation departments are to adhere to NCQA Quality metrics in credentialing or delegating plan functions to providers. The departments conduct collection of practitioner and facility credentialing documents, ensure quality assessments of providers, perform ongoing monitoring of network providers, and conduct the Credentialing Committee. The Delegation section ensures that Molina's

delegated providers are compliant to regulatory requirements by auditing the delegates periodically, and assessing their performance relative to NCQA and Molina's Quality standards.

- **Provider Network Administration (PNA).**The PNA department ensures that provider data collected from all areas of the health plan is entered accurately in Molina's provider database. This data can range from the data entry of a provider's practice address to the complex configuration of provider contract reimbursement. PNA also oversees the Molina Provider Directory data and ensures its accuracy.
- **Encounters.**
  The Encounter department ensures that Molina**'s data** is compliant to its agreement with Centennial Medicaid**. The Encounter team performs retrospective review to ensure that Member's received the right care, in the right place, at the right time, with the right provider specialty.**

Section 2 – Contact Information

Provider Services

Provider Services and other areas within Network Management and Operations including Provider Contracting, Provider Inquiry, Research and Resolution and Provider Reconsideration Review/Appeals.

Provider Services **Provider Services and Engagement Representative Territory Grid** **PSR Territory Grid**	
Address:	Molina Healthcare of New Mexico, Inc. 400 Tijeras NW, Suite 200 Albuquerque, NM 87102
Phone:	(855) 322-4078
Fax:	(505) 798-7313

Member Services

Member Services for Member benefits, eligibility, selecting or changing primary care practitioner (PCP) and Member complaints.

Member Services	
Address:	Molina Healthcare of New Mexico, Inc. 400 Tijeras NW, Suite 200 Albuquerque, NM 87102
Phone:	(855) 322-4078
TTY/TDD:	711

Member Appeals and Grievances

Services Available in English and Spanish
In Albuquerque: (505) 342-4663 Toll Free: (800) 723-7762 Fax: (505) 342-0583
TTY/TDD: 711 Relay

Claims Department

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

- Access the Provider Portal (https://provider.molinahealthcare.com)
- EDI Payer ID 09824

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

Claims	
Phone:	(855) 322-4078

Provider Inquiry Research and Resolution (PIRR), Provider Reconsideration Review (PRR)/Appeals

Provider Inquiry Research and Resolution (PIRR), Provider Reconsideration Review (PRR)/Appeals

PIRR: Physical Health: MHNMProviderInquiries@Molinahealthcare.com Behavioral Health: MHNMBHInquiries@Molinahealthcare.com LTSS: MHNMLTSSInquiry@Molinahealthcare.com
PRR: Toll Free Fax: (855) 378-3642
Appeals: Toll Free Fax: (855) 348-3643

Claims Recovery Department

The Claims Recovery Department manages recovery for Overpayment

Claims Recovery	
Address	Molina Healthcare of New Mexico, Inc. PO Box 22801 Long Beach, CA 90801
Phone:	(855) 322-4078

Compliance and Fraud AlertLine

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

Molina Healthcare AlertLine – 24 hours a day/7 days a week	
Address:	Molina Healthcare of New Mexico, Inc. 400 Tijeras Ave. NW, Suite 200 Albuquerque, NM 87102
Phone:	(866) 606-3889

Website: **https://molinahealthcare.alertline.com**

Care Coordination

Care Coordination
Toll Free Phone: (855) 315-5677
Toll Free Fax: (866-472-4575 for complex, chronic conditions

Credentialing Department

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

Credentialing	
Address:	Molina Healthcare of New Mexico, Inc. 400 Tijeras NW, Suite 200 Albuquerque, NM 87102
Email: MHNMCredentialing@Molinahealthcare.com	
Phone:	(855) 322-4078

Nurse Advice Line

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

Nurse Advice Line (HEALTHLINE) **24 hours per day, 365 days per year**
English Phone: (888) 275-8750 Spanish Phone: (866) 648-3537
TTY/TDD: 711 Relay

Healthcare Services (UM) Department

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

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

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

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

- Submit requests directly to Molina Healthcare via the Provider Portal. See our Provider Web Portal Quick Reference Guide or contact your Provider Services Representative for registration and submission guidance.

Healthcare Services **Authorizations & Inpatient Census**
Provider Portal: https://provider.molinahealthcare.com
Address: Molina Healthcare of New Mexico, Inc. 400 Tijeras NW, Suite 200 Albuquerque, NM 87102
Physical Health
Toll Free Phone: (877) 262-0187
Toll Free Fax: (888) 802-5711
NICU, Radiology and Transplant Authorizations
Toll Free Phone: (877) 731-7218 - NICU: (877) 731-7220 - Transplant: (877) 813-1206
Pharmacy – Benefits, Medical Office Drugs, I.V. Infusion, TPN
Toll Free Phone: (855) 322-4078 Toll Free Fax: (877) 731-7218

Health Management

Molina Healthcare's Health Management includes weight management, smoking cessation, and certain disease related programs. These services can be incorporated into the Member's treatment plan to address the Member's health care needs.

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

Behavioral Health

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

Behavioral Health
Address: Molina Healthcare of New Mexico, Inc. 400 Tijeras NW, Suite 200 Albuquerque, NM 87102
Phone: (855) 322-4078
(24) Hours per day, (365) day per year: (888) 275-8750

Dental

Member Services – Eligibility and Benefits
Albuquerque: (505) 341-7493 Toll Free Phone: (855) 322-4078
Scion Dental – for Provider Inquiries (claims, credentialing) Toll Free Phone: (800) 508-6965

Vision

March Vision
Toll Free Phone: (844) 706-2724

Transportation

Secure
Toll Free Phone: (888) 593-2052

Provider Web Portal Services

Healthcare's Provider Web Portal (Provider Portal) is an easy to use, online tool available to all of our Providers at no cost. The Provider Portal offers the following functionality:

- Verify and print Member eligibility
- Claims Functions
  - Professional and Institutional Claims (individual or multiple claims)

    - Receive notification of Claims status change
    - Correct Claims
    - Void Claims
    - Add attachments to previously submitted claims
    - Check Claims status
    - Export Claims reports
- Prior Authorizations/Service Requests
    - Create and submit Prior Authorization Requests
    - Check status of Authorization Requests
    - Receive notification of change in status of Authorization Requests
    - Attach medical documentation required for timely medical review and decision making
- View HEDIS® Scores and compare to national benchmarks

Register today to access our on-line services. A video will guide you through the easy on-line registration process. Link into our Web Portal at: Web Portal - Provider Self-Serve Upon registration, practitioners/providers and their staff will be able to perform the following tasks on-line through Web Portal:

Molina Healthcare Website

Molina Healthcare's website provides information, materials, news, updates and much more. Log on to our website at www.molinahealthcare.com to access the following information:

- Provider Manual;
- Provider forms;
- Provider Policies;
- Health Insurance Portability and Accountability Act (HIPAA) Resource Center;
- Electronic Data Interchange (EDI), Electronic Fund Transfer/Remittance Advice (EFT/ERA) information;
- Drug list;
- Health Resources;
- Provider Newsletters;
- Provider Communications;
- Contact information;
- Clinical Practice Guidelines;
- Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) Scores;
- Provider Coding Tools;
- Disease Management/Health Management Programs;
- Preventive Health Guidelines; and
- Critical Incident Reporting.

HealthXnet Service

Molina Healthcare is contracted with Hospital Services Corporation (HSC) to provide on-line services for providers through HealthXnet. Upon registration, you and your office staff will be able to perform the following tasks on-line through HealthXnet: Member eligibility, claims status and Service Request (prior authorization status).

To register, contact HealthXnet (low monthly subscription fees will apply):

HealthXnet Support Desk
Albuquerque: (505) 346-0290
Toll free: (866) 676-0290 healthxnet@nmhsc.com www.healthxnet.com

Section 3 – Provider Responsibilities/Participation Requirements

Prior to contracting with Molina Healthcare, providers must be enrolled with New Mexico Medicaid. All providers with a National Provider Identifier (NPI) that is not associated with an active New Mexico Medicaid Fee-For-Service or Managed Care Provider record (status 60 or 70) in the Omnicaid system and has or will provide health care services are required to enroll with the New Mexico Medical Assistance Division (MAD) Medicaid Program.

Joining a Practice

Any practitioner changes (i.e. joining or leaving a practice) must be communicated to the appropriate Molina Healthcare Provider Services Representative and should be initiated at least thirty (30) days prior to the actual date of the change.

New Molina Healthcare Provider

- Complete a Provider Information Form (PIF) that is located on our Provider Website at PIF Form
- Complete the New Mexico Disclosure Form – this must be completed and submitted with the PIF located on our Provider Website at Disclosure Form
- Provide your CAQH (please make sure all information is up to date) information on the PIF, or complete a Credentialing Application;
- Send to your designated Provider Service Representative (fax or email); and
- Sign the appropriate contractual agreement, if necessary.

Existing Molina Healthcare Provider:

- Notify your designated Provider Service Representative of the change in practice within thirty (30) days of change. If notification is not received within thirty (30) days, new credentialing must be completed (follow above steps as a new provider);
- Joining an existing contracted provider? Notification within thirty (30) days; or
- Opening a new practice? Notification within thirty (30) days; Complete New Mexico Disclosure Form; Complete a W-9; and if you are a PCP, OB/GYN or High Volume Behavioral Health, a site visit may be required.

Leaving a Practice/ Provider Termination

All Molina Healthcare contracted practitioners/providers and/or provider groups must notify Molina Healthcare and his/her Molina Healthcare patients of termination of an individual provider or of the entire group thirty (30) days prior to the effective date of termination. When terminating a Contracted Provider with Molina Healthcare:

- Notify your Provider Services Representative in writing;
- The Provider Services Representative will remove the terminating provider from various databases (including those that affect the production of an online or printed directory),claims processing system; and
- Molina Healthcare's Enrollment Department will notify Members of PCP changes. A Member assigned to a terminated PCP will be given adequate time to select a new PCP. If a new PCP is not selected, one will be assigned to him/her from a list of participating PCPs in his/her geographic area that is accepting new patients.

On-Call Arrangements

Molina Healthcare contracted providers must use practitioners that are contracted with Molina Healthcare for on-call arrangements. Practitioners must contact Molina Healthcare and obtain a prior authorization if a non-contracted practitioner is needed for on-call.

Primary Care Practitioner (PCP) Responsibilities

The Centennial Care PCP is a medical or behavioral health practitioner responsible for supervising, coordinating, and providing primary health care to Member's initiating referrals for specialist care, and maintaining the continuity of the Member's care.

1. The PCP provides all the Member's primary care health services. PCPs are responsible for twenty-four (24) hour, seven (7) day-a-week coverage. Members are instructed to contact their PCP prior to seeking care in all cases except life threatening emergencies. Members who require care for a life-threatening emergency are instructed to notify their PCP within twenty-four (24) hours of emergency treatment. A family Member may make this notification. If electronic answering machines are used, messages should include the following: 1) Name and telephone number of the on-call practitioner, with instructions to contact that practitioner; and 2) A disclaimer that if the Member presents to the emergency room or urgent care facility without contacting the on-call practitioner, payment by Molina Healthcare can be denied.
2. When specialized care is needed, the PCP will provide a referral to a participating specialist. The PCP should ensure the information from the specialty practitioner is reviewed and included in the Member's medical record within ninety (90) days after the conclusion of treatment. If the Member requires care which can only be provided outside of Molina Healthcare's provider panel, the PCP will work with Molina Healthcare and/or Medical Director to arrange for the appropriate services;
3. Upon request, the PCP is required to provide the Member information about the PCP's education, training, applicable certification, and any subspecialty;
4. All lab and imaging services ordered by the PCP must be performed either in the

PCP's office, the office of Molina Healthcare's preferred/participating practitioner/provider or laboratory, or at one of the participating hospitals or outpatient centers;

5. All elective hospital inpatient, residential treatment, skilled nursing facility, and home health care admissions must be approved in advance by the PCP or the admitting practitioner (if a referral has been made by the PCP). The PCP or admitting practitioner must coordinate care with hospitals that require in-house staff to examine or treat Members. The PCP, specialist and hospitalist caring for a Member with special health care needs should contact Molina Healthcare to assist in coordination of care with the assigned Care Coordinator;
6. Use outpatient surgical services whenever medically appropriate;
7. Advise the Member of advance directive processes available. The Member can obtain forms by calling our Member Service Department;
8. The PCP maintains Member medical records in accordance with the standards established by Molina Healthcare's that are outlined in this section; and
9. The PCP is responsible for the education and training of all individuals working with his/her medical practice to assure that the procedures for Molina Healthcare's managed care delivery system are followed correctly. Representatives of the Provider Services Department are available to provide staff training which may include referral, grievance and billing procedures.

PCPs, BH practitioners, and other practitioners/providers should play an active role in the Member's BH treatment. One of the most important things to remember is that the Member and his/her family must be a part of the treatment planning process.

The role of the PCP is to refer the Member to the appropriate level of behavioral health care. Although a referral is not required for a Molina Healthcare Member to directly access behavioral health care, the PCP should be available to assist the Member in accessing needed behavioral health services. The PCP will offer a Member a referral for behavioral Health Services based upon the following indicators:

- Suicidal/homicidal ideation or behavior;
- At-risk of hospitalization due to a BH condition;
- Children or adolescents at imminent risk of out-of-home placement in a psychiatric acute care hospital or residential treatment facility;
- Trauma victims;
- Serious threat of physical or sexual abuse of risk to life or health due to impaired mental status and judgment, mental retardation, or other developmental disabilities;
- Request by Member or Representative for BH services;
- Clinical status that suggests need for BH services;
- Identified psychosocial stressors and precipitants;
- Treatment compliance complicated by behavioral characteristics;
- Behavioral and psychiatric factors influencing medical conditions;
- Victims or perpetrators of abuse and/or neglect and Members suspected of being

subject to abuse and/or neglect;
- Non-medical management of substance abuse;
- Follow-up to medical detoxification;
- An initial PCP contact or routine physical exam indicates a substance abuse problem;
- A prenatal visit indicates substance abuse problems;
- Positive response to questions indicates substance abuse, observation of clinical indicators or laboratory values that indicate substance abuse;
- A pattern of inappropriate use of medical, surgical, trauma, or emergency room services that could be related to substance abuse or other BH conditions; and/or
- The persistence of serious functional impairment.

Molina Healthcare defines a medical emergency as a condition that manifests itself by symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in: (a) jeopardy to the Member's health; or (b) serious impairment of bodily functions; or (c) serious dysfunction of any bodily organ or part; or (d) disfigurement of the person.

PCP Role in an Emergency Situation

To assist in reducing inappropriate use of emergency department (ED) facilities during normal business hours, PCPs MUST have a health professional available to triage patients under the following circumstances:

- Patients who walk into a PCP's office should be evaluated in a reasonable time frame to determine the emergent nature of the condition, and treatment should be scheduled that corresponds to the immediacy of the situation;
- Telephonic requests to the PCP's office by Members must be assessed to determine appropriate action;
- Telephonic requests to the PCP's office from other practitioners requesting approval to treat Members must be assessed for appropriateness; and
- The PCP must then advise the Member on a medically prudent course of action (i.e. whether to come to the office or to be referred for treatment to the emergency room at a participating hospital or urgent care center).

If the PCP is not available, practitioner back-up as part of the triage system should be provided by a practitioner having the same level or higher of training and specialty. PCPs are not required to submit referrals for patients they refer to an ER, but are encouraged to direct Members to appropriate care.

Out-of-Area Emergencies

Coverage for out-of-area emergencies is provided only for true emergency situations - those that could not have been anticipated. Routine medical services are not covered when provided outside the service area. Members are instructed to seek care at the nearest appropriate facility such as a clinic, urgent care center, or hospital Emergency Department.

When notified of an out-of-area emergency, which requires follow-up or has resulted in an

inpatient admission, the PCP is expected to monitor the Member's condition, arrange for appropriate care, and determine whether the Member can be safely transferred to a participating hospital.

Individualized Education Program (IEP) & PCP

The IEP is a written plan of care created for every child with a disability attending school. The IEP is a principle tenet of the Individuals with Disabilities Education Act (IDEA) that is developed, written and as appropriate, revised in accordance with the Act. It is the cornerstone for a special education student, ensuring his/her right to a free and appropriate education, including medically necessary services.

In addition to academic services, speech/language therapy, occupational therapy, physical therapy, social work, health services (i.e. medications, tube feedings), audiology and psychological services may be provided.

The primary care practitioner (PCP) for the child must receive a copy of the child's IEP if Medicaid reimbursable services are being requested. The PCP must then sign off on the plan of care to ensure he/she is aware of the medically necessary services that his/her patient is receiving at school.

It is important that the PCP sign off on the IEP and return it to the designated contact in the school setting. Per IDEA, schools are required to provide medically necessary services. However, without the PCP's signature, the schools cannot bill for services rendered. There is ***no medical liability or financial loss to the PCP*** in approving these services.

For more information on IEPs or the Medicaid School Services Based Program, please contact:

Medicaid School Based Services Program Manager
Medical Assistance Division Benefits Bureau
Local in Santa Fe (505) 827-6233, or
Medicaid School Based Services Program Director
Medical Assistance Division Benefits Bureau
Local in Santa Fe (505) 827-3199

Specialist as PCP

A Member may select a board-certified specialist as PCP if clinically appropriate and if the specialist agrees to provide PCP services. Members are advised in the Member Handbook that, if appropriate, they may use a Specialist as a PCP based on a special health care need. Board-certified physicians from appropriate specialty areas function as PCPs. Board-certified psychiatrists are the only behavioral health practitioners who qualify and may serve as PCPs.

Specialty Provider Responsibilities

When the PCP determines that a Molina Healthcare Member needs to see a specialist, the PCP initiates a referral. It is important for specialty practitioners/providers to advise the PCP when follow-up care is necessary. The specialty practitioner may treat as necessary within the

parameters of the referral from the PCP that is appropriate (i.e. lab tests, radiology, therapies, etc.). If the Member requires a procedure for which prior authorization is required, including hospitalization, the specialty practitioner is responsible for obtaining the proper authorization from Molina Healthcare.

Specialty practitioners will ensure that services provided are documented and sent to the Member's primary care practitioner within ninety (90) days after the conclusion of each treatment. The specialty practitioner will be responsible for the education and training of all individuals working within his/her medical practice to assure that Molina Healthcare's procedures are followed correctly. Upon request, the specialty practitioner is required to provide the Member with information about the specialty practitioner's/provider's education, training, applicable certification, and any subspecialty.

The specialty practitioner will advise the Member of advance directive processes available. Members may obtain forms by calling the Member Service Department.

Under certain circumstances, and with prior approval, a specialist can act as the Member's PCP for some chronic or long-term care conditions. Call the Provider Services Department for more information.

Critical Incident Reporting

Providers delivering Home and Community Based Services (HCBS) are responsible for Incident Management. All providers rendering Centennial Care funded services to the HCBS population are required to report critical incidents and to develop and implement an incident management system that at minimum maintains, tracks, and trends data from the reports and includes the data in quality assurance activities.

Community agencies providing HCBS are required to report critical incidents to the State Human Services Division (HSD) using their online Critical Incident Reporting portal (https://criticalincident.hsd.state.nm.us). HCSBS includes, but are not limited to, Personal Care services, Self-Directed Benefit services, Behavioral Health (BH) services, and Home Health services.

All allegations of Abuse, Neglect, and Exploitation of a Member must be reported, as well as any incidents involving Emergency Services, Hospitalization, the Death of a Member the involvement of Law Enforcement, any Environmental Hazards that compromise the health and safety of a Member, and any Elopement of Missing Member.

Agencies that do not comply with the incident reporting requirements are in violation of state statues and federal regulations, and may be sanctioned up to and including termination of their Provider Agreement with Molina or by the HSD Medical Assistance Division.

Providers are expected to cooperate with any investigation conducted by the Molina Healthcare

Quality Improvement Department by providing additional information as requested. Request for additional information may include: root cause analysis, documentation from internal investigations, policies and procedures, site visits, chart reviews and staff/Member interviews. Some investigations may be part of a collaboration with HSD Behavioral Health Collaborative, New Mexico Department of Health, (Child Protective Services and Adult Protective Services.

For more information about critical incident reporting requirements, contact the Quality Improvement Department toll free at: **(800) 377-9594, ext. 180343.**If you have questions regarding these requirements, please contact Provider Services toll free at (800) 377-9594.

Abuse and/or Neglect Reporting

Every person who knows or has reasonable suspicion that a child or adult is being abused or neglected in New Mexico must report the matter immediately. Specific professionals mentioned under the law as mandated reporters are: licensed physicians, residents or interns, law enforcement officers, judges presiding during a proceeding, nurses, schoolteachers, school officials, social workers, and Members of the clergy who have information not privileged as a matter of law.

- **Child Abuse**: Children, Youth, and Family Department's (CYFD) Statewide Central Intake child abuse hotline toll free at (855)333-SAFE [7233] or #SAFE from a cell phone, or to law enforcement or the appropriate tribal identity. Additional information regarding Child Protective Services can be found at: Children Youth and Family Department Central Abuse Line
- **Adult Abuse**: Adult Protective Services (APS) toll free Hotline at (866) 654-3219 or at (505)476-4912. Additional information regarding Adult Protective Services can be found on their website at: http://www.nmaging.state.nm.us/Contact_Us.aspx

Advance Directives

It is the policy of Molina Healthcare to ensure that all Members have access to information regarding the right to make informed decisions about their medical treatment, even when they can no longer speak for themselves. Advance Directive means written instructions (such as an Advance Health Directive, a Mental Health Advance Directive, a Psychiatric Advance Directive, a Living Will, a Durable Health Care Power of Attorney, or a Durable Mental Health Care Power of Attorney) recognized under State law relating to the provision of care when an individual is incapacitated.

Advance directives forms are state specific to meet state regulations. For copies of forms applicable to New Mexico, please go to the Caring Connections website at http://www.caringinfo.org/files/public/ad/NewMexico.pdf

A mental health or psychiatric advanced directive (PAD) is a legal document designed to preserve the autonomy of an individual with mental illness during times when the mental illness temporarily compromises the individual's ability to make or communicate mental health treatment decisions.

The Mental Health Care Treatment Decision Act gives all individuals >18 years of age the right to have a psychiatric advance directive and provides direction on the completion of a PAD and how organizations and providers must utilize a PAD. The law includes a standard PAD form, which is optional and not mandatory. For more information on PAD's in New Mexico and for a copy of the PAD form, link to: National Resource Center on Psychiatric Advance Directives

All practitioner/provider office personnel with Member contact must maintain a general knowledge of this policy and the contents of the "Advance Directives" article text.

Nondiscrimination of Health Care Service Delivery

Molina Healthcare complies with the guidance set forth in the final rule for Section 1557 of the Affordable Care Act, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina Healthcare of New Mexico, Inc. (Molina Healthcare) website home pages. All Providers who join the Molina Healthcare Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Molina Healthcare requires Providers to deliver services to Molina Healthcare Members without regard to race, color, national origin, age, disability or sex. This includes gender identity, sexual orientation, pregnancy and sex stereotyping. Providers must post a non-discrimination notification in a conspicuous location of their office along with translated non-English taglines in the top fifteen (15) languages spoken in the state to ensure Molina Members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred.

Additionally, Participating Providers or contracted medical groups/IPAs may not limit their practices because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high cost-care.

Section 1557 Investigations

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

Molina Healthcare
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802
Toll Free: (866) 606-3889
TTY/TDD: 711
On Line: https://molinahealthcare.AlertLine.com
Email: civil.rights@molinahealthcare.com

Facilities, Equipment and Personnel

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

Provider Data Accuracy and Validation

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

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

Providers must validate the Provider Online Directory (POD) information at least quarterly for correctness and completeness. Providers must notify Molina in writing at least thirty (30) days in advance, when possible, of changes such as, but not limited to:

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

Please visit our Provider Online Directory at https://providersearch.molinahealthcare.com to validate your information. Please notify your Provider Services Representative if your information needs to be updated or corrected.

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

Molina Healthcare 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. Providers are required to provide timely responses to such communications.

Molina Electronic Solutions Requirements

Molina Healthcare requires Providers to utilize electronic solutions and tools.

Molina Healthcare requires all contracted Providers to participate in and comply with Molina Healthcare's Electronic Solution Requirements, which include, but are not limited to, electronic

submission of prior authorization requests, health plan access to electronic medical records (EMR), electronic claims submission, electronic fund transfers (EFT), electronic remittance advice (ERA) and registration for and use of Molina Healthcare's Provider Web Portal (Provider Portal).

Electronic claims include claims submitted via a clearinghouse using the electronic data interchange (EDI) process and claims submitted through the Molina Provider Web Portal.

Any Provider insisting on paper claims submission and payment via paper check will be ineligible for Contracted Provider status within the Molina Healthcare network.

Any Provider entering the network as a Contracted Provider will be required to comply with Molina Healthcare's Electronic Solution Policy by registering for Molina's Provider Web Portal, and submitting electronic claims upon entry into the network. Providers entering the network as a Contracted Provider must enroll for EFT and electronic remittance advice (ERA) payments within thirty (30) days of entering the Molina network.

Electronic Solutions/Tools Available to Providers
Electronic Tools/Solutions available to Molina Healthcare Providers include:

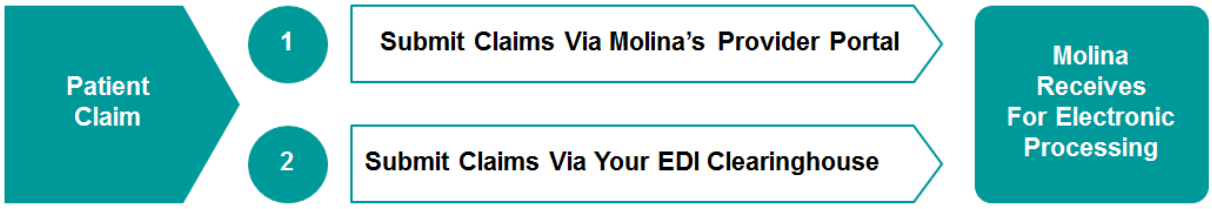
- Electronic Claims Submission Options
- Electronic Payment (Electronic Funds Transfer) with ERA
- Provider Web Portal

Electronic Claims Submission Requirement
Molina Healthcare requires Participating Providers to submit claims electronically. Electronic claims submission provides significant benefits to the Provider including:

- Ensures Health Insurance Portability and Accountability Act (HIPAA) compliance
- Helps to reduce operational costs associated with paper claims (printing, postage, etc.)
- Increases accuracy of data and efficient information delivery
- Reduces claim delays since errors can be corrected and resubmitted electronically
- Eliminates mailing time and claims reach Molina faster

Molina offers the following electronic Claims submission options:

- Submit claims directly to Molina Healthcare of New Mexico, Inc. via the Provider Portal. See our Provider Web Portal Quick Reference Guide https://provider.molinahealthcare.com or contact your Provider Services Representative for registration and Claim submission guidance.
- Submit Claims to Molina through your EDI clearinghouse using Payer ID 09824, refer to our website www.molinahealthcare.com for additional information.



While both options are embraced by Molina Healthcare, Providers submitting claims via Molina's Provider Portal (available to all Providers at no cost) offers a number of claims processing benefits beyond the possible cost savings achieved from the reduction of high-cost paper claims including:

- 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

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

Electronic Payment (EFT/ERA) Requirement
Participating Providers are required to enroll for EFT and ERA. Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services allow Providers to reduce paperwork, the ability to have searchable ERAs, and to receive payment and ERA access faster than the paper check and RA processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Molina Healthcare uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery.

Below is the link to register with Change Healthcare ProviderNet to receive electronic payments and remittance advices. Additional instructions on how to register are available under the EDI/ERA/EFT tab on Molina's website: www.molinahealthcare.com.

Any questions during this process should be directed to Change Healthcare Provider Services at wco.provider.registration@changehealthcare.com or 877-389-1160.

Gross Receipts / Sales Tax
Molina Healthcare will reimburse Gross Receipt Tax (GRT) to applicable providers who meet the following criteria:

- The provider's practice is a for-profit entity; and
- They are required to pay GRT to the State of New Mexico.

Gross Receipts/Sales tax cannot be added to the charges of any patient who is a Member of a

Health Plan or insurer of which a provider has made an agreement with to accept their reimbursement (Division of Insurance Regulation, 13 NMAC 10.13.27). Information such as tax tables and forms for Gross Receipts tax can be found on the New Mexico Taxation and Revenue Website: http://www.tax.newmexico.gov/gross-receipts-taxes.aspx

Provider Web Portal

Providers are required to register for and utilize Molina Healthcare's Provider Web Portal (Provider Portal). The Provider Portal is an easy to use, online tool available to all of our Providers at **no cost**. The Provider Portal offers the following functionality:

- Verify and print member eligibility
- Claims Functions
    - Professional and Institutional Claims (individual or multiple claims)
    - Receive notification of Claims status change
    - Correct Claims
    - Void Claims
    - Add attachments to previously submitted claims
    - Check Claims status
    - Export Claims reports
    - Appeal Claims
- Prior Authorizations/Service Requests
    - Create and submit Prior Authorization Requests
    - Check status of Authorization Requests
    - Receive notification of change in status of Authorization Requests
- View HEDIS® Scores and compare to national benchmarks

Balance Billing

Providers contracted with Molina cannot bill the Member for any covered benefits. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers may not charge Members fees for covered services beyond copayments.

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

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

Member Rights and Responsibilities

Providers are required comply with the Member Rights and Responsibilities as outlined in Member materials (such as Member Evidence of Coverage documents). More information is available in the Member Rights and Responsibilities section in this Provider Manual.

Member Information and Marketing

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

Member Eligibility Verification

Providers should verify eligibility of Molina Healthcare Members prior to rendering services. Payment for services rendered is based on enrollment and benefit eligibility. The contractual agreement between Providers and Molina Healthcare places the responsibility for eligibility verification on the Provider of services.

Possession of a Molina Healthcare Marketplace ID Card does not guarantee Member eligibility or coverage. A Provider must verify a recipient's eligibility each time the recipient presents to their office for services. More information on Member eligibility verification options is available in the Eligibility, Enrollment, Disenrollment and Grace Period section of this Manual.

Healthcare Services (Utilization Management and Case Management)

Providers are required to participate in and comply with Molina Healthcare's Healthcare Services programs and initiatives. Clinical documentation necessary to complete medical review and decision making is to be submitted to Molina through electronic channels such as the Provider Portal. Clinical documentation can be attached as a file and submitted securely through the Provider Portal. Please see the Healthcare Services section of the Manual for additional details about these and other Healthcare Services programs.

In Office Laboratory Tests

Effective March 1, 2018: Molina Healthcare's policies allow only certain lab tests to be performed in a practitioner/physician's office regardless of the line of business. All other lab testing must be referred to an In-Network Laboratory Provider that is a certified, full service laboratory, offering a comprehensive test menu that includes routine, complex, drug, genetic testing and pathology. A list of those lab services that are allowed to be performed in the practitioner/ physician's office is found on the Molina website at www.molinahealthcare.com.

For more information about In-Network Laboratory Providers, please consult the Molina Healthcare Provider Directory (https://providersearch.molinahealthcare.com/). For testing available through In-Network Laboratory Providers, or for a list of In-Network Laboratory Provider patient services centers, please reach out to the In-Network Laboratory Provider.

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

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

Referrals
A referral is necessary when a Provider determines Medically Necessary services are beyond the scope of the primary care practitioner's (PCP's) practice or it is necessary to consult or obtain services from other in-network specialty health professionals (please refer to the Healthcare Services section of this Manual). Information is to be exchanged between the PCP and Specialist to coordinate care of the patient to ensure continuity of care. Providers need to document in the patient's medical record any referrals that are made. Documentation needs to include the specialty, services requested, and diagnosis for which the referral is being made.

Providers should direct Members to health professionals, hospitals, laboratories, and other facilities and Providers which are contracted and credentialed (if applicable) with Molina Healthcare Marketplace. In the case of and Emergency Services, Providers may direct Members to an appropriate service including but not limited to primary care, urgent services. There may be circumstances in which referrals may require an out of network Provider; prior authorization will be required from Molina Healthcare except in the case of Emergency Services.

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

Admissions
Providers are required to comply with Molina Healthcare's facility admission, prior authorization, and Medical Necessity review determination procedures.

Participation in Utilization Review and Care Management Programs
Providers are required to participate in and comply with Molina's utilization review and Care Management programs, including all policies and procedures regarding prior authorizations. This includes the use of an electronic solution for the submission of documentation required for medical review and decision making. Providers will also cooperate with Molina Healthcare in audits to identify, confirm, and/or assess utilization levels of covered services.

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

Treatment Alternatives and Communication with Members
Molina Healthcare endorses open Provider-Member communication regarding appropriate treatment alternatives and any follow up care. Molina promotes open discussion between Provider and Members regarding Medically Necessary or appropriate patient care, regardless of covered benefits limitations. Providers are free to communicate any and all treatment options to Members regardless of benefit coverage limitations. Providers are also encouraged to promote and facilitate training in self-care and other measures Members may take to promote their own health.

Prescriptions
Providers are required to adhere to Molina Healthcare's drug formularies and prescription policies.

Pain Safety Initiative (PSI) Resources
Safe and appropriate opioid prescribing and utilization is a priority for all of us in health care. Molina Healthcare requires Providers to adhere to Molina Healthcare'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 Healthcare is dedicated to ensuring Providers are equipped with additional resources, which can be found on the Molina Healthcare Provider website. Providers may access additional Opioid-safety and Substance Use Disorder resources at www.molinahealthcare.com under the Health Resource tab. Please consult with your Provider Services Representative or reference the medication formulary for more information on Molina's Pain Safety Initiatives.

Participation in Quality Programs
Providers are expected to participate in Molina Healthcare's Quality Programs and collaborate with Molina Healthcare in conducting peer review and audits of care rendered by Providers.

Additional information regarding Quality Programs is available in the Quality section of this Manual.

Access to Care Standards
Molina Healthcare is committed to providing timely access to care for all Members in a safe and healthy environment. Molina Healthcare will ensure Providers offer hours of operation no less than offered to commercial Members. Access standards have been developed to ensure that all health care services are provided in a timely manner. The PCP or designee must be available twenty-four (24) hours a day, seven (7) days a week to Members for Emergency Services. This access may be by telephone. For additional information about appointment access standards please refer to the Quality section of this Manual.

The following information contained in this section defines the minimum requirements of timely access to care.

Access Type	Request for Appointment or Wait Time
Routine, asymptomatic, Member-initiated, outpatient appointments for primary medical care	Request-to-appointment time will be no more than thirty (30) days (unless the Member requests a later time)
Routine asymptomatic, Member-initiated dental appointments	Request-to-appointment time will be consistent with community norms for dental appointments
Routine, symptomatic, Member-initiated, outpatient appointments for non-urgent primary medical and dental care	Request-to-appointment time will be no more than fourteen (14) days (unless the Member requests a later time)
Primary medical and dental care, outpatient appointments for urgent conditions	Will be available within twenty-four (24) hours
Specialty outpatient referral and/or consultation appointments	Request-to-appointment time will be consistent with the clinical urgency but no longer than twenty-one (21) days (unless the Member requests a later time)
Routine outpatient diagnostic laboratory, diagnostic imaging, and other testing appointments	Request-to-appointment time will be consistent with the clinical urgency but no more than fourteen (14) days (unless the Member requests a later time)
Routine, asymptomatic, Member-initiated Behavioral Health Appointments	Request-to-appointment time will be within fourteen (14) days
Behavioral Health Urgent Care Appointment	Request-to-appointment time will be within twenty-four (24) hours
Behavioral Health Crisis Services Appointment	Request-to-appointment time will be within two (2) hours
Behavioral Health Life-threatening Emergency	Immediate Access
Post-Discharge Behavioral Health Appointment	Follow up appointment within seven (7) days
After Hours Care	Twenty-four (24) hour coverage
Outpatient diagnostic laboratory, diagnostic imaging and other testing appointments, if a “walk in” rather than an appointment system is used	Wait time will be consistent with severity of the clinical need
Urgent outpatient diagnostic laboratory, diagnostic imaging, and other testing appointments	Request-to-appointment time will be consistent with the clinical urgency, but no more than forty-eight (48) hours

Access Type	Request for Appointment or Wait Time
Pharmacy Services	In-person prescription fill time (ready for pickup) will be no longer than forty (40) minutes; a prescription phoned in by a practitioner will be filled within ninety (90) minutes
Durable Medical Equipment (DME) ▪ Urgent ▪ Non-urgent ▪ New customized or made to measure DME, or customized modifications to existing DME owned or rented by the Member ▪ DME repairs or non-customized modifications	▪ Will be delivered within twenty-four (24) hours of the request ▪ Will be delivered within a timeframe consistent with clinical need ▪ Will be delivered within one hundred fifty (150) days of request ▪ Will be delivered within sixty (60) days of request date
Transportation Services	Require three (3) business days' advance notice. Transportation for sudden, urgent situations may be arranged with less notice.
Member Service Telephone Services ▪ Average Speed to Answer ▪ Average Abandonment Rate ▪ Answer ninety-five percent (85%) of Member calls	▪ ≤ Thirty (30) seconds ▪ ≤ Five percent (5%) ▪ ≤ Thirty (30) seconds

The use of telehealth technology is supported to improve access to care in rural and frontier areas of the state. Molina Healthcare offers technical assistance, training and other support for providers willing to provide or receive services via telehealth technology.

Molina Healthcare monitors Member access to care through a number of mechanisms including:

- Annual After-Hours Telephone Survey: Provider offices are called after business hours to determine whether the call was answered by a live-person or a recording; whether or not emergency instructions were provided; and had sufficient means to speak with a practitioner;
- Annual Appointment Availability Survey: Telephone surveys are conducted annually to measure performance against Access Standards for Primary Medical Care Services; Annual Member Satisfaction Survey; conducted annually through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey;

- Ongoing Member Complaints Data: The rate of Member complaints relating to access and availability of care;
- Ongoing Report of Member Telephone Statistics: Molina Healthcare assesses the accessibility of Member services through ongoing measurements of average speed to answer; average abandonment rates; and percentage of calls answered within thirty (30) seconds or less; and
- Annual Healthcare Effectiveness Data and Information Set (HEDIS®) Access and Availability of Care Measures: These measures look at how Members access services from his/her health care delivery system, such as: adult's access to preventive/ambulatory services; children's access to PCPs; timeliness of prenatal and postpartum care; and annual dental visits.

On an annual basis, Molina Healthcare compiles results from the various monitoring activities to conduct a comprehensive analysis to identify barriers and areas for improving Member access to care.

- Molina Healthcare requires that all contracted practitioners/providers offer the same office hours to Molina Healthcare Members that are offered to all other patients under Commercial Plans and/or Medicaid Fee for Service.

Vaccines for Children Program

Molina Healthcare practitioners located in New Mexico are required to enroll in the Vaccines for Children (VFC) Program. VFC provides vaccines at no charge to immunize Molina Healthcare Members under the age of eighteen (18).

- Enrolling with VFC, contact VFC at (866) 681-5872. **For more information, please see the New Mexico Immunization Program's website at:** http://nmhealth.org/about/phd/idb/imp and/or
- The New Mexico Statewide Immunization Information System to record immunizations administered in your clinic or healthcare facility, contact the NMSIIS website at: https://nmsiis.health.state.nm.us/webiznet_nm/Login.aspx

Transition of Care after Termination

All Molina Healthcare contracted practitioners/providers terminating their contracted status with Molina Healthcare, including groups, are required to follow appropriate Transition of Care guidelines for Molina Healthcare patients under a current course of treatment or care of the terminating provider or group. This includes seeing Molina patients for no more than ninety (90) calendar days after termination until the Molina Healthcare patient's current episode of care is resolved or until the Molina Healthcare patient has been appropriately transitioned to another contracted Molina Healthcare practitioner/provider.

The practitioner/provider will also:

- Not bill any Molina patients in this ninety (90) transition period for Covered Services with the exception of any applicable Copayments, Deductibles and/or Coinsurance;
- Accept the non-par rate reflected in NMAC Program Rules as payment in full during the ninety (90) Day transition period or until such time as the Molina

patient's episode of care is resolved or is transitioned to another contracted Molina Healthcare practitioner/provider;
- Continue to follow Molina Healthcare's Utilization Managed policies and procedures; and
- Share any information requested, included medical records, regarding the treatment plan with Molina Healthcare.

Site and Medical Record-Keeping Practice Reviews
As a part of Molina Healthcare's Quality Improvement Program, Providers are required to maintain compliance with certain standards for safety, confidentiality, and record keeping practices in their practices.

Providers are required to maintain an accurate and readily available individual medical record for each Member to whom services are rendered. Providers are to initiate a medical record upon the Member's first visit. The Member's medical record (electronic preferred or hard copy) should contain all information required by State and Federal Law, generally accepted and prevailing professional practice, applicable government sponsored health programs and all Molina's policies and procedures. Providers are to retain all such records for a minimum of ten (10) years and retained further if the records are under review or audit until the review or audit is complete.

Centers for Medicare & Medicaid Services (CMS) has specific guidelines for the retention and disposal of Medicare records. Please refer to CMS General Information, Eligibility, and Entitlement Manual, Chapter 7, Chapter 30.30 for guidance.

Delivery of Patient Care Information
Providers must comply with all State and Federal Laws, and other applicable regulatory and contractual requirements to promptly deliver any Member information requested by Molina Healthcare for use in conjunction with utilization review and management, grievances, peer review, HEDIS® Studies, Molina Healthcare's Quality Programs, or claims payment. Providers will further provide direct access to patient care information (hard copy or electronic) as requested by Molina Healthcare and/or as required to any governmental agency or any appropriate State and Federal authority having jurisdiction.

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

Confidentiality of Member Protected Health Information (PHI) and HIPAA Transactions
Molina Healthcare requires that Providers respect the privacy of Molina Healthcare Members (including Molina Healthcare 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 (PHI).

Additionally, Providers must comply with all HIPAA transactions, code sets, and identifiers (TCI) regulations. Providers must obtain a National Provider Identifier (NPI) and use their NPI in HIPAA Transactions, including claims submitted to Molina Healthcare.

Participation in Grievance and Appeals Programs

Providers are required to participate in Molina Healthcare's Grievance Program and cooperate with Molina Healthcare 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 appeals, the Provider will participate by providing medical records and/or statement as needed. This includes the maintenance and retention of Member records for a period of not less than ten (10) years, and retained further if the records are under review or audit until such time that the review or audit is complete.

Please refer to the Complaints, Grievance and Appeals Process section of this Manual for additional information regarding this program.

Participation in Credentialing

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

Providers must notify Molina Healthcare no less than thirty (30) days in advance when they relocate or open an additional office. When this notification is received, a site review of the new office may be conducted before the Provider's recredentialing date.

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

Delegation

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

Section 4 – Cultural Competency and Linguistic Services

Background

Molina Healthcare works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the US Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina Healthcare complies with Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA) Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) and other regulatory/contract requirements. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency and Members who are deaf, hard of hearing or have speech or cognitive/intellectual impairments. Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds and religions as well as those with disabilities in a manner that recognizes values, affirms and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on cultural competency and linguistic services is available at www.Molina Healthcarehealthcare.com, from your local Provider Services Representative and by calling Molina Healthcare Provider Services at (855) 322-4078.

Nondiscrimination of Healthcare Service Delivery

Molina Healthcare complies with the guidance set forth in the final rule for Section 1557 of the ACA, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina Healthcare website home pages. All Providers who join the Molina Healthcare Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Molina Healthcare requires Providers to deliver services to Molina Healthcare Members without regard to race, color, national origin, age, disability or sex. This includes gender identity, sexual orientation, pregnancy and sex stereotyping. Providers must post a non-discrimination notification in a conspicuous location of their office along with translated non-English taglines in the top fifteen (15) languages spoken in the state to ensure Molina Healthcare Members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred.

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

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

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

Should you or a Molina Healthcare Member need more information you can refer to the Health and Human Services website for more information: https://www.federalregister.gov/d/2016-11458

Molina Healthcare Institute for Cultural Competency

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

Provider and Community Training

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

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

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

Integrated Quality Improvement – Ensuring Access

Molina Healthcare ensures Member access to language services such as oral interpreting, American Sign Language (ASL), written translation and access to programs, and aids and services that are congruent with cultural norms. Molina Healthcare supports Members with disabilities, and assists Members with Limited English Proficiency.

Molina Healthcare develops Member materials according to Plain Language Guidelines. Members or Providers may also request written Member materials in alternate languages and formats, leading to better communication, understanding and Member satisfaction. Online materials found on www.Molina Healthcarehealthcare.com and information delivered in digital form meet Section 508 accessibility requirements to support Members with visual impairments.

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

Program and Policy Review Guidelines

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

- Annual collection and analysis of race, ethnicity and language data from:
    - Eligible individuals to identify significant culturally and linguistically diverse populations with plan's membership
    - Revalidate data at least annually
    - Contracted Providers to assess gaps in network demographics
- Local geographic population demographics and trends derived from publicly available sources (Group Needs Assessment)
- Applicable national demographics and trends derived from publicly available sources
- Network Assessment
- Collection of data and reporting for the Diversity of Membership HEDIS measure.
- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages.
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations.
- Analysis of HEDIS and CAHPS results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.
- Comparison with selected measures such as those in Healthy People 2010

Measures available through national testing programs such as the National Health and Nutrition Examination Survey (NHANES) Linguistic Services

Molina Healthcare provides oral interpreting of written information to any plan Member who speaks any non-English language regardless of whether that language meets the threshold of a prevalent non-English language. Molina Healthcare notifies plan Members of the availability of oral interpreting services upon enrollment, and informs them how to access oral interpreting services at no cost to them on all significant Member materials. Molina Healthcare serves a diverse population of Members with specific cultural needs and preferences. Providers are responsible for supporting access to interpreter services at no cost for Members with sensory impairment and/or who have Limited English Proficiency.

24 Hour Access to Interpreter Services

Providers may request interpreters for Members whose primary language is other than English by calling Molina Healthcare's Contact Center. If Contact Center Representatives are unable to interpret in the requested language, the Representative will immediately connect you and the Member to a language service provider. Molina Healthcare Providers must support Member access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset. Providers may offer Molina Healthcare Members interpreter services if the Members do not request them on their own. It is never permissible to ask a family member, friend or minor to interpret.

Documentation

As a contracted Molina Healthcare 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 Healthcare.
- Document all Member requests for interpreter services.
- Document who provided the interpreter service. This includes the name of Molina Healthcare's internal staff or someone from a commercial interpreter service vendor. Information should include the interpreter's name, operator code and vendor.
- Document all counseling and treatment done using interpreter services.
- Document if a Member insists on using a family member, friend or minor as an interpreter, or refuses the use of interpreter services after notification of his or her right to have a qualified interpreter at no cost.

Members with Hearing Impairment

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

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

Molina Healthcare will provide face-to-face service delivery for ASL to support our members with hearing impairment. Requests should be made three days in advance of an appointment to ensure availability of the service. In most cases, members will have made this request via Molina Healthcare Member Services.

Nurse Advice Line

Molina Healthcare provides twenty four (24) hours/seven (7) days a week Nurse Advice Services for members. The Nurse Advice Line provides access to twenty-four (24) hour interpretive services. Members may call Molina Healthcare Healthcare's Nurse Advice Line directly (English line (888) 275-8750) or (Spanish line at (866) 648-3537) or for assistance in other languages. The Nurse Advice TTY/TDD is 711. The Nurse Advice Line telephone numbers are also printed on membership cards.

Section 5 – Member Eligibility, Enrollment and Health Assessment

Member Eligibility

HSD determines eligibility for enrollment in the Centennial Care Program. All individuals determined to be Medicaid eligible are required to participate in the Centennial Care Program unless he or she is: (1) a Native American and elects enrollment in the Medical Assistance Division's fee-for-service (FFS) program; or (2) is in an excluded population.

A Native American who does not meet a nursing facility level of care or intermediate care facility for individuals with intellectual disabilities (ICF/IID) levels of care or is not dually-eligible for both Medicaid and Medicare will not be enrolled in the Centennial Care Program unless the eligible recipient elects to enroll.
The following eligible recipients are excluded from Centennial Care Program enrollment:

1. Qualified Medicare beneficiaries (QMB)-only recipients;
2. Specified low-income Medicare beneficiaries;
3. Qualified individuals;
4. Qualified disabled working individuals;

5. Refugees;
6. Participants in the program for all inclusive care for the elderly (PACE); and
7. Children and adolescents in out-of-state foster or adoption placements.

Member Enrollment

The New Mexico Human Services Department (HSD) will enroll individuals determined eligible for Centennial Care. Enrollment with Molina Healthcare may be the result of a recipient's selection or assignment by HSD.

Upon Enrollment with Molina Healthcare, Members receive a Welcome Packet that includes:

- Welcome Letter;
- Member Handbook – The Member handbook contains information advising the Member that the provider directory is available on-line and that assistance with any of the formats may be received by contacting Member Services;
- Provider Directory – The Member is contacted within 30 calendar days of enrollment. At that time, Molina will ask how the Member wants the provider directory provided to them. A CD format will be appropriate if the Member indicates they are computer literate. If the Member is not computer literate, printed copies will be provided to the Member.
- Notice of Privacy Practices;
- Primary Care Provider (PCP) Selection form and postage paid envelope;
- Quit4Life informational brochure; and
- Nurse Advice Line magnet.

Centennial Care Members enrolled with Molina Healthcare of New Mexico are provided with an identification card. The card includes:

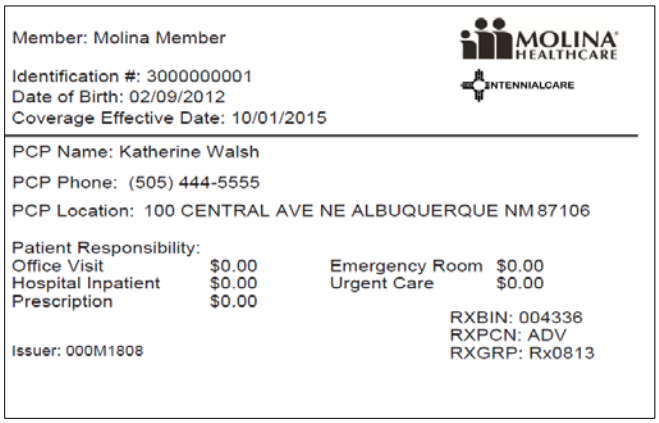
- Telephone numbers for information and/or authorizations, including for physical health, behavioral health, and long-term care supports services;
- Descriptions of procedures to be followed for emergency or special services;
- Member identification number, name, date of birth, enrollment effective date, and PCP; and
- Member co-payment amounts for covered services.

The back of Molina Healthcare's Member identification card provides important information on obtaining services and telephone numbers for our providers and Members to utilize as needed.

At each office visit, your office staff should:

- Ask for the Member's ID Card;
- Copy both sides of the ID Card and keep the copy with the patient's files; and
- Determine if the Member is covered by another health plan, and record information for coordination of benefits. If the Member is covered by another health plan, the provider must submit to the other carrier(s) first. After the other carrier(s) pay, submit the claim to Molina Healthcare.

Sample of Molina Healthcare of New Mexico Centennial Care ID Card:



Members, due to their category of eligibility based on income-level, may qualify for the Alternative Benefit Plan, which has copayment requirements for some covered services.

Children's Health Insurance Program (CHIP) copayment requirements:

- $2.00 per prescription (applies to prescription and non-prescription drug items);
- $5.00 per outpatient visit (including physician or other practitioner visits, therapy sessions, and behavioral health sessions;
- $5.00 per dental visit (unless all the services are preventive services; and
- $25 per inpatient hospital admission unless the hospital is receiving the eligible member as a transfer from another hospital.

Working Disabled Individual (WDI) copayment requirements:

- $3.00 per prescription (applies to prescription and non-prescription drug items);
- $7.00 per outpatient visit (including physician or other practitioner visits, therapy sessions, and behavioral health sessions;

- $7.00 per dental visit (unless all the services are preventive services; and
- $30 per inpatient hospital admission unless the hospital is receiving the eligible member as a transfer from another hospital.

Copayments will be reflected on the Member ID Card and can be found on the Provider Web Portal.

PCP Assignment

After a Member has been enrolled for 15 calendar days, a primary care practitioner (PCP) is assigned to the Member with the exception of Dual Eligible Members (enrolled in both Medicaid and Medicare who are assigned or have previously selected a PCP accepting Medicare). The Member will receive an identification card showing the assigned PCP. ID cards for Dual Eligible Members will not reflect a PCP. Individual family Members may choose the same or different PCPs.

Members may choose a PCP from the list of participating practitioners in one of the following specialties:

- Family Practice, General Practice;
- Certified Nurse Practitioner and Physician Assistants;
- Internal Medicine;
- Gerontology;
- Pediatrics;
- OB/GYN – Female Members may self-refer to a women's health care provider. Some OB/GYNs act as a PCP. In this case, the OB/GYN is listed under the Primary Care Section of the Provider Directory; and
- Specialists, on an individualized basis, for Members whose care is more appropriately managed by a specialist, such as Members with infectious diseases, chronic illness, etc. A board-certified psychiatrist may serve as a PCP for Members with complex behavioral health conditions or disabilities.
- I/T/Us (Indian Health Services, Tribal 638 and Urban Indian Providers may be designated as PCPs as appropriate).

Change in PCP Assignment

Member Initiated

The Member has the right to change that PCP and may call Molina Healthcare with the change request. When a Member changes PCPs, Molina Healthcare will issue a new identification card to the Member. Members may initiate a PCP change at any time, for any reason. The request for PCP change may be made in writing or by telephone. If the change is requested by the twentieth of the month, it will become effective the first day of the following month. If the request is made after the twentieth day, it will become effective the first day of the second month following the request.

Members presenting at a PCP's office **to whom they are not assigned,** may request a change of

PCP by filling out and signing a "Member Authorization to Change Primary Care Practitioner" Form. The form should then be faxed or emailed to Molina Healthcare and a new identification card will be sent to the Member. This form may be found at PCP Change Form

PCP Initiated

Molina Healthcare asks that you document the need for these changes in writing to the Provider Services Department, with the specific reasons for the request. **Reasonable Cause Does Not Include a Member's Health Status.** Please submit documentation to:

Molina Healthcare of New Mexico, Inc.
Provider Services Department
P. O. Box 3887
Albuquerque, NM, 87190 - 9859 OR
Fax to (505) 798-7313

PCPs are responsible for providing basic care and emergency coverage for up to thirty (30) days after the date of your change letter, or until we can confirm the Member has made a change in his/her PCP, whichever is less. The PCP initiating the Member's change is responsible for the copy and transfer of the Member's medical records to the new PCP.

Molina Healthcare Initiated Change of PCP

Molina Healthcare may initiate a PCP change for a Member under the following circumstances:

a. Molina Healthcare and the Member agree that assignment to a different PCP is in the Member's best interest, based on the Member's medical condition;
b. A Member's PCP ceases to be a Molina-contracted practitioner;
c. A Member's behavior towards the PCP is such that it is not feasible to safely or prudently provide medical care, and the PCP has made reasonable efforts to accommodate the Member;
d. A Member has initiated legal actions against the PCP;
e. The PCP is suspended for any reason; and /or
f. Based on claims data, Members will be automatically reassigned to the PCP they are actually visiting, rather than the one initially assigned through the PCP auto assignment process. This "re-paneling" process will be executed on the 20th of each month. Establishing accurate panels will allow Molina Healthcare to appropriately measure primary care utilization, capacity, assess patient characteristics, and generate clinical quality indicators based on an accurate denominator. This will also allow Molina Healthcare staff and the Member's PCP to better direct outreach and quality initiatives to the appropriate Members.

PCP/Medical Practitioner Lock-In

When concerns about misuse of unnecessary services and/or prescription drugs by a Member are identified, Molina Healthcare may place a Member into "lock-in." This program is called Patient Review and Restriction (PRR). Enrollment in the PRR Program is usually for twelve months.

PCP Lock-In:
Molina Healthcare may require that a Member see a certain PCP while ensuring reasonable access to quality services when:

- Utilized services have been identified as unnecessary;
- A Member's behavior is detrimental; and/or
- A need is indicated to provide care continuity.

Molina Healthcare utilizes claims data, emergency room reports, pharmacy claims reports, New Mexico Prescription Monitoring Program reports, Care Coordination Referral Forms, Provider Complaints and Nurse Advice Line reports to identify when a Member's behavior requires placement into Lock-In.

Identified behaviors include, but are not limited to: excessive emergency room utilization, excessive PCP change requests, provider reports of drug demands when not medically indicated and non-compliance to treatment plans, self-referral to pain management providers, and excessive "no-shows" to provider appointments.

A Member may be considered for lock-in/PRR if their utilization history shows:

a. Any of the following conditions have been met or exceeded in a ninety-day period within the past year:
    - The Member has received services from four or more different practitioners, or
    - Has had controlled substance prescriptions filled by three or more different pharmacies, or
    - Has received excessive prescriptions and/or quantities of controlled substances as documented in Rx claims history and/or NM Prescription Monitoring Program reports, or
    - Has received controlled substance prescriptions from three or more different prescribers not in the same medical practice especially emergency department providers, or
    - Has received opioid prescriptions while on opioid replacement therapy.
    - Has received similar services from two or more practitioners in the same day; or
b. The Member has made two or more visits to emergency departments for similar services within a 90-day period in the past year; or
c. The Member has a medical history at-risk utilization patterns within the past year; or
d. The Member has made repeated and documented efforts to seek medically unnecessary health services within the past year; and has been counseled at least once by a health care provider or managed care plan representative about the appropriate use of health care services.

When the conditions listed above are met, a medical director reviews the Member's diagnosis, history of services provided, or other relevant medical information (e.g., prescription claims

history). The Medical Director must determine that the documented utilization shows both of the following:

- That the utilization is all related to one problem, and is not an unlucky coincidence of appropriate treatment for several different problems; and
- That continuation of services from multiple providers constitutes inappropriate, unsafe, or medically unnecessary medical practice or overuse of medical services (as defined in applicable New Mexico statutes and regulations) medical services well beyond the patient's medically necessary care).

If the reviewing medical director finds that the Member is using inappropriate, unsafe, or medically unnecessary services, Molina Healthcare staff will follow policies and procedures to initiate restrictions.

Prior to placing a Member into medical provider lock-in, Molina will inform the Member and/or Member's Representative of the intent to lock-in, including the reasons for imposing the lock-in and notice that the restriction does not apply to emergency services furnished to the Member.

a. Molina Healthcare's grievance procedure will be made available to any Member being designated for PCP lock-in.
b. The PCP lock-in will be reviewed, documented and reported to HSD every month.
c. The Member will be removed from PCP lock-in when it has determined that the utilization problems have been solved and that recurrence of the problems is judged to be improbable.
d. HSD will be notified of all lock-in removals.

The Member's input will be required to select an assigned medical practitioner for lock-in. Depending on circumstances, this practitioner may be the Member's PCP, pain specialist, oncologist, Suboxone or methadone provider or another medical practitioner who has a relationship with the Member and a reason to provide the Member with prescriptions for drugs with abuse potential. The medical practitioner chosen by the Member must be agreeable to acting as the practitioner and manager of the Member's prescriptions for medications with abuse potential. Molina Healthcare's grievance procedure will be made available to a Member disagreeing with the lock-in process.

The lock-in will be reviewed and documented by Molina Healthcare and reported to HSD every month. The Member will be removed from lock-in when Molina Healthcare has determined that the utilization problems or detrimental behavior has ceased and that recurrence of the problems is judged to be improbable. HSD will be notified of all lock-in removals.

Criteria for ending lock-in/PRR for a Member are as follows:

a. The Member has been in the program for 12 months, and
b. Review of clinical, prescribing, and billing information shows that the Member's care has been reasonable and appropriate, or the PCP handling the lock-in/PRR restrictions reports that the services requested have been reasonable and appropriate, or

c. One of the following early-termination criteria are met:
d. The Member disenrolls or otherwise leaves the plan; or
e. The Member's health status changes and the program is no longer necessary or is a hindrance to ongoing medical care.

Member Disenrollment
A Member may request to be disenrolled from Molina Healthcare for cause at any time, even during a lock-in period. The Member must submit a written request to HSD for approval.

Transition of Care for New Molina Healthcare Members
Molina Healthcare will authorize medically necessary health care services for a new Member who has been authorized to receive these services by their previous Medicaid health plan, the Health Insurance Marketplace and/or fee-for-service Medicaid upon enrollment to Molina Healthcare as defined by State regulation.

The utilization reviewer and/or care manager will contact the new Member and the new Member's current practitioner/provider to determine the transition of care needs of the Member to a Molina Healthcare contracted practitioner/provider.

Continuity of Care

Continuity of Care Following Transition between Two Managed Care Organizations (MCOs)
Practitioners/providers will receive pertinent Member information, with Member consent, when the Member transitions from one managed care organization to another, including information related to key medical conditions, authorization data, assessment results, and service coordination and/or care management status, including a copy of the current Care Plan.

It is Molina Healthcare's policy to provide Members with advance notice when a Provider they are seeing will no longer be in network. Members and Providers are encouraged to use this time to transition care to an in-network Provider. The Provider leaving the network shall provide all appropriate information related to course of treatment, medical treatment, etc. to the Provider(s) assuming care. Under certain circumstances, Members may be able to continue treatment with the out of network Provider for a given period of time. For additional information regarding continuity of care and transition of Members, please contact Molina Healthcare toll free at (855) 322-4081.

Continuity of Care Following Member Loss of Eligibility
If the Member's eligibility ends and the Member needs continued treatment, Molina Healthcare will inform the Member of alternative options for care that may be available through a local or state agency.

Continuity of Care and Communication after Practitioner Termination

The provider leaving the network will provide all appropriate information related to course of treatment, medical treatment, etc. to the provider(s) assuming care. Molina Healthcare stresses the importance of timely communication between providers involved in a member's care. This is especially critical between specialists, including behavioral health providers, and the member's PCP. Information should be shared in such a manner as to facilitate communication of urgent needs or significant findings.

a. Molina Healthcare allows any Member whose treating practitioner leaves the network during an episode of care, to continue diagnostic or therapeutic endeavors with that practitioner until the current episode of care (an active course of treatment for an acute medical condition or ongoing treatment of a chronic medical condition) terminates or until ninety (90) days have elapsed since the practitioner's contract ended, whichever is shorter;
b. Molina Healthcare will authorize this continuity of care only if the health care practitioner/provider agrees to:
    - Accept reimbursement from Molina Healthcare at the rates applicable prior to the start of the transitional period as payment in full; and
    - Adhere to Molina Healthcare's quality assurance requirements and to provide to Molina Healthcare necessary medical information related to such care.

Under no circumstances will Members be permitted to continue care with practitioners/providers who have been terminated from the network for quality of care, barred from participation based on existing Medicare, Medicaid or Health Insurance Marketplace sanctions (except for Emergency Services) or fraud reasons.

Member Notification of PCP and Specialist Termination

Molina Healthcare will notify Members in writing of their PCP's termination within thirty (30) calendar days of the receipt of the termination. A notification will be sent to a Member if they have seen a PCP within the last 90 days even if he/she was not assigned to the terminating provider. A new Molina Healthcare identification card is mailed to the Member reflecting their choice of a new PCP or assignment to a new PCP.

Molina Healthcare will notify the Member in writing of their specialist's termination when the Member has received services from that specialist within the ninety (90) days immediately prior to the specialist's termination.

Molina Healthcare Care Coordinators will work with providers to gather information needed to create a transition plan, some of which is required to submit to the New Mexico Human Services Department if the termination of any one provider is deemed substantial.

Member Health Assessment

Molina Healthcare will identify Members with complex physical and/or behavioral health needs through screening and health assessments performed by Care Managers at the time of enrollment. The staff will obtain basic health demographic information to complete a Health

Risk Assessment (HRA). The HRA results will determine the necessary level of care management, identify any cultural or disability sensitivities and determine the need for a Comprehensive Needs Assessment (CNA).

The results of the HRA will be communicated to Molina Healthcare's Care Management team for evaluation of the appropriate level of care and any special accommodations. Members identified will be referred for the appropriate level of Care Management and Care Coordination, and a Molina Healthcare Care Manager will develop a Care Plan to address the Members functional needs, medical conditions, behavioral health needs, and social and environmental needs in collaboration with the Member's family, PCP, and other professional practitioners/providers or agencies involved in their care.
The Care Coordination Queue is available during normal business house Monday through Friday from 8:00 a.m. – 5:00 p.m. Please call or refer Members to **toll free (855) 315-5677.**

Molina Healthcare Initiated Disenrollment of Member

Molina Healthcare may request disenrollment of a Member from its health plan when:

1. A good faith effort has been made to accommodate the Member and address the Member's problems but those efforts have been unsuccessful;
2. The conduct of the Member does not allow Molina Healthcare to safely or prudently provide medical, behavioral and/or LTSS subject to the terms of its contract with HSD;
3. Molina Healthcare has offered to the Member in writing the opportunity to use its grievance procedures;
4. Molina Healthcare has received threats or attempts of intimidation from the Member to its staff or to practitioners or their staff.

Disenrollment will not be requested because of an adverse change in the Member's health status or because of the Member's utilization of services, diminished mental capacity or uncooperative or disruptive behavior resulting from the Member's special needs, except when continued enrollment seriously impairs the ability to furnish services to either the Member or other Members.

Section 6 – Member Rights and Responsibilities

All contracted Molina Healthcare providers must abide by the Member rights and responsibilities as outlined below.

Member Rights

1. Members or their legal guardians have a right to receive information about Molina Healthcare, Molina Healthcare's policies and procedures regarding products, services, its contracted practitioners and providers, grievance procedures, benefits provided and Member rights and responsibilities;
2. Members have a right to be treated with courtesy and consideration, equitably and with respect and recognition of their dignity and right and need for privacy;
3. Members or their legal guardians have a right to choose a primary care practitioner (PCP) within the limits of the covered benefits and plan network, and the right to refuse care of specific practitioners or to notify the provider if changes need to be requested;
4. Members or their legal guardians have a right to receive from the Member's practitioner/provider, in terms that the member or legal guardian(s) understands, an explanation of his or her complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives, irrespective of the health care insurer's or Molina Healthcare's position on treatment options. If the Member is not capable of understanding the information, the explanation be provided to his or her next of kin, guardian, agent or surrogate, if available, and documented in the member's medical record;
5. Members have a right to receive health care services in a non-discriminatory fashion;
6. Members who do not speak English as their first language have the right to access translator services at no cost for communication with Molina Healthcare;
7. Members who have a disability have the right to receive information in an alternative format in compliance with the Americans with Disabilities Act;
8. Members or their legal guardians have a right to participate with their health care practitioner/provider in decision making in all aspects of their health care, including the treatment plan development, acceptable treatments and the right to refuse treatment;
9. Members or their legal guardians have the right to informed consent;
10. Members or their legal guardians have the right to choose a surrogate decision-maker to be involved, as appropriate, to assist with care decisions;
11. Members or their legal guardians have the right to seek a second opinion by another provider in the Molina Healthcare network when Members need additional information regarding recommended treatment or believe the provider is not authorizing requested care;
12. Members have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage;
13. Members or their legal guardians have a right to voice complaints, grievances or appeals about Molina Healthcare, the handling of grievances, or the care provided and make use of

Molina Healthcare's grievance process and the Human Service Department (HSD) hearings process, at no cost, without fear of retaliation;

14. Members or their legal guardians have a right to file a complaint, grievance or appeal with Molina Healthcare or the HSD Administrative Hearings Bureau, for Medicaid Members, and to receive an answer to those complaints, grievances or appeals within a reasonable time;
15. Members or their legal guardians have a right to choose from among the available practitioners and providers within the limits of Molina Healthcare's network and its referral and prior authorization requirements;
16. Members or their legal guardians have a right to make their decisions known through advance directives regarding health care decisions (i.e., living wills, right to die directives, "do not resuscitate" orders, etc.) consistent with federal and state laws and regulations;
17. Members or their legal guardians have a right to privacy of medical and financial records maintained by Molina Healthcare and its providers, in accordance with existing law;
18. Members or their legal guardians have a right to access the Member's medical records in accordance with the applicable federal and state laws and regulations;
19. Members have the opportunity to consent to or deny the release of identifiable medical or other information by Molina Healthcare, except when such release is required by law;
20. Members have a right to request an amendment to their Protected Health Information (PHI) if the information is believed to be incomplete or wrong;
21. Members or their legal guardians have a right to receive information about Molina Healthcare, its health care services, how to access those services, the network practitioners and providers (i.e., title and education) and the Patient Bill of Rights;
22. Members or their legal guardians have a right to be provided with information concerning Molina Healthcare's policies and procedures regarding products, services, practitioners and providers, appeal procedures, obtaining consent for use of Member medical information, allowing members access to their medical records, and protecting access to member medical information, and other information about Molina Healthcare and benefits provided;
23. Members or their legal guardians have a right to know upon request of any financial arrangements or provisions between Molina Healthcare and its practitioners and providers which may restrict referral or treatment options or limit the services offered to Members;
24. Members or their legal guardians have a right to be free from harassment by Molina Healthcare or its network practitioners or providers in regard to contractual disputes between Molina Healthcare and practitioners or providers;
25. Members or their legal guardians have a right to available and accessible services when medically necessary as determined by the primary care practitioner (PCP) or treating provider in consultation with Molina Healthcare, twenty-four (24) hours per day, seven (7) days per week for urgent or emergency care services, and for other health care services as defined by the contract or evidence of coverage;
26. Members have a right to adequate access to qualified health professionals near where the Member lives or works, within the service area of Molina Healthcare;
27. Members have a right to affordable health care, with limits on out-of-pocket expenses, including the right to seek care from a non-participating Provider, and an explanation of a

Member's financial responsibility when services are provided by a non-participating provider/ or non-participating practitioner, or provided without required pre-authorization;

28. Members or their legal guardians have a right to prompt notification of termination or changes in benefits, services or Provider network;
29. Members have a right to seek care from a non-participating provider and be advised of their financial responsibility if they receive services from a non-participating provider, or receive services without required Prior Authorization;
30. Members have the right to continue an ongoing course of treatment for a period of at least thirty (30) calendar days. This will apply if the Member's provider leaves the Provider network, or if a new Member's provider is not in the Provider network;
31. Members have the right to make recommendations regarding the organization's Member Rights and Responsibilities policy;
32. Members have a right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion;
33. Members or their legal guardians will have the right to select a Managed Care Organization (MCO) and exercise switch enrollment rights without threats or harassment;
34. Members have a right to detailed information about coverage, maximum benefits and exclusions of specific conditions, ailments or disorders, including restricted benefits and all requirements that an enrollee must follow for prior approval and utilization review;
35. Members or their legal guardians have all the rights afforded by law, rule, or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the Member understands;
36. Members or their legal guardians have the right to a complete explanation of why care is denied, an opportunity to appeal the decision to Molina Healthcare's internal review, the right to a secondary appeal, and the right to request the superintendent's or HSD's assistance as applicable;
37. Members or their legal guardians have the right to get information, when they ask, that HSD determines is important during the Member's first contact with the MCO. This information can include a request for information about the MCO's structure, operation and/or practitioners or senior staff's incentive plans; and
38. Members or their legal guardian are be free to exercise his/her rights and that exercising those rights will not result in adverse treatment of the Member or their legal guardian.

Member Responsibilities

Molina Healthcare enrolled Members and/or his/her guardian(s) has the responsibility to:

1. Provide, to the extent possible, information that Molina Healthcare and its providers need in order to care for him/her.
2. Understand the Member's health problems and to participate in developing mutually agreed upon treatment goals.
3. Follow the plans and instructions for care that he/she have agreed on with his/her practitioner(s).
4. Keep, reschedule or cancel an appointment rather than to simply fail to show-up.

5. Review his/her Member Handbook or Evidence of Coverage and if there are questions contact the Member Services Department for clarification of benefits, limitations and exclusions. The Member Services telephone number is located on the Member's Identification Card.
6. Follow Molina Healthcare's policies, procedures and instructions for obtaining services and care.
7. Show his/her Member Identification Card each time he/she goes for medical care and to notify Molina Healthcare immediately of any loss or theft of his/her identification card.
8. Advise a participating provider of coverage with Molina Healthcare at the time of service. Members may be required to pay for services if he/she does not inform the participating provider of his/her coverage.
9. Pay for all services obtained prior to the effective date with Molina Healthcare and subsequent to termination or cancellation of coverage with Molina Healthcare.
10. Notify his/her Income Support Division Caseworker if there is a change in his/her name, address, telephone number, or any changes in his/her family.
11. Notify HSD and Molina Healthcare if he/she gets medical coverage other than through Molina Healthcare.
12. Pay for all required co-payments and/or coinsurance at the time services are rendered.

Section 7 – Centennial Care Covered Services

Molina Healthcare provides and coordinates comprehensive and integrated health care benefits to each of its enrolled Members and covers the physical health, behavioral health and long-term LTSS benefits as directed by HSD.

Community Benefit

For Members meeting nursing facility level of care, Molina Healthcare provides the Community Benefit, as determined appropriate based on the Member's Comprehensive Needs Assessment. The **Community Benefit** means both the **Agency-Based Community Benefit and the Self-Directed Community Benefit** subject to an individual's annual allotment as determined by HSD. Members eligible for the Community Benefit will have the option to select either the Agency- Based Community Benefit or the Self-Directed Community Benefit.

- Members selecting the Agency-Based Community Benefit will have the option to select their personal care service provider; and
- Members may also select the Self-Directed Community Benefit, which affords them the opportunity to have choice and control over how services are provided and how much certain providers are reimbursed in accordance with range of rates per service established by HSD.

Agency-Based Community Benefit Services
Adult Day Health
Assisted Living
Behavior Support Consultation
Community Transition Services
Emergency Response
Employment Supports
Environmental Modifications
Home Health Aide
Personal Care Services
Private Duty Nursing for Adults
Respite
Skilled Maintenance Therapy Services
Self-Directed Community Benefit Services
Behavior Support Consultation
Customized Community Support
Emergency Response
Employment Supports
Environmental Modifications
Home Health Aide
Homemaker/Personal Care
Nutritional Counseling

Private Duty Nursing for Adults
Related Goods
Respite
Skilled Maintenance Therapy Services
Specialized Therapies
Transportation (non-medical)

Table of Centennial Care Non-Community Benefit Covered Services

Non-Community Benefit Services
Accredited Residential Treatment Center Services
Adult Psychological Rehabilitation Services
Ambulatory Surgical Center Services
Anesthesia Services
Applied Behavior Analysis
Assertive Community Treatment Services
Behavior Management Skills Development Services
Behavioral Health Professional Services: outpatient behavioral health and substance
Case Management
Community Interveners for the Deaf and Blind
Comprehensive Community Support Services
Day Treatment Services
Dental Services
Diagnostic Imaging and Therapeutic Radiology Services
Dialysis Services
Durable Medical Equipment and Supplies
Emergency Services (including emergency room visits and psychiatric ER)
Experimental or Investigational Procedures, Technology or Non-Drug Therapies[1]
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
EPSDT Personal Care Services
EPSDT Private Duty Nursing
EPSDT Rehabilitation Services
Family Planning
Family Support (Behavioral Health)
Federally Qualified Health Center Services
Hearing Aids and Related Evaluations
Home Health Services
Hospice Services
Hospital Inpatient (including detoxification services)
Hospital Outpatient
Inpatient Hospitalization in Freestanding Psychiatric Hospitals
Intensive Outpatient Program Services
IV Outpatient Services
Laboratory Services

Medication Assisted Treatment for Opioid Dependence
Midwife Services
Multi-Systemic Therapy Services
Non-Accredited Residential Treatment Centers and Group Homes
Nursing Facility Services
Nutritional Services
Occupational Services
Outpatient Hospital based Psychiatric Services and Partial Hospitalization
Outpatient and Partial Hospitalization in Freestanding Psychiatric Hospital
Outpatient Health Care Professional Services
Pharmacy Services
Physical Health Services
Physical Therapy
Physician Visits
Podiatry Services
Pregnancy Termination Procedures
Preventive Services
Prosthetics and Orthotics
Psychosocial Rehabilitation Services
Radiology Facilities
Recovery Services (Behavioral Health)
Rehabilitation Option Services
Rehabilitation Services Providers
Reproductive Health Services
Respite (Behavioral Health)
Rural Health Clinics Services
School-Based Services
Smoking Cessation Services
Speech and Language Therapy
Swing Bed Hospital Services
Telehealth Services
Tot-to-Teen Health Checks
Transplant Services
Transportation Services (medical)
Treatment Foster Care
Treatment Foster Care II
Vision Care Services

[1]Experimental and investigational procedures, technologies or therapies are only available to the extent specified in MAD 8.325.6.9 or its successor regulation.

Table of Alternative Benefit Plan (ABP) - Covered Services

The Alternative Benefit Plan is a low-cost insurance plan for adults ages nineteen (19) to sixty-four (64). Under ABP, there are cost sharing amounts that are based on Federal Poverty Level (FPL) percentages. This will impact newly eligible adults up to 138% of FPL.

Alternative Benefit Plan Services Included Under Centennial Care
Allergy testing and injections
Annual physical exam and consultation[1]
Autism spectrum disorder (through age 22)[2]
Bariatric surgery[3]
Behavioral health professional and substance abuse services, evaluations, testing, assessments, therapies and medication management
Cancer clinical trials
Cardiac rehabilitation[4]
Chemotherapy
Dental services[5]
Diabetes treatment, including diabetic shoes, medical supplies, equipment and education
Dialysis
Diagnostic imaging
Disease management
Drug/Alcohol dependency treatment services, including outpatient detoxification, therapy, partial hospitalization and intensive outpatient program (IOP) services
Durable medical equipment, medical supplies, orthotic appliances and prosthetic devices, including repair or replacement[6]
Electroconvulsive therapy
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, including routine oral and vision care, for individuals age 19 and 20
Emergency services, including emergency room visits, emergency transportation, psychiatric emergencies and emergency dental care
Family planning and reproductive health services and devices, sterilization, pregnancy termination and contraceptives[7]

1 Includes a health appraisal exam, laboratory and radiological tests and early detection procedures.

2 Covers speech, occupational and physical therapy, and applied behavioral analysis for recipients' age 19-20; or age 21-22 who are enrolled in high school.

3 Limited to one per lifetime. Criteria may be applied that considers previous attempts by the member to lose weight, BMI and health status.

4 Limited to short-term therapy (two consecutive months) per cardiac event.

5 The ABP covers dental services for adults in accordance with 8.3.10.7 NMAC. Recipients age 19-20 may receive dental services according to the increased periodicity under EPSDT.

6 Requires a provider's prescription. DME is limited to a periodicity schedule and must be medically necessary. Disposable medical supplies are limited to diabetic and contraceptive supplies. Foot orthotics, including shoes and arch supports, are covered only when an integral part of a leg brace, or are diabetic shoes.

7 Sterilization reversal is not covered. Infertility treatment is not covered.

Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) services
Genetic evaluation and testing[8]
Habilitative and rehabilitative services, including physical, speech and occupational therapy[9]
Hearing screening as part of a routine health exam[10]
Holter monitors and cardiac event monitors
Home health, skilled nursing and intravenous services[11]
Hospice care services
Hospital inpatient and outpatient services
Immunizations[12]
Inhalation therapy
Inpatient physical and behavioral health hospital/medical services and surgical care[13]
Inpatient rehabilitative services/facilities[14]
IV infusions
Lab tests, x-ray services and pathology
Maternity care, including delivery and inpatient maternity services and pre- and post-natal care
Mammography, colorectal cancer screenings, pap smears, PSA tests and other age appropriate tests
Medication assisted treatment for opioid dependence
Non-emergency transportation when necessary to secure covered medical services and/or treatment
Nutritional evaluations and counseling – dietary evaluation and counseling as medical management of a documented disease, including obesity
Organ and Tissue Transplants[15]
Osteoporosis diagnosis, treatment and management
Outpatient Surgery

[8] Limited to Triple Serum Test and genetic testing for the diagnosis or treatment of a current illness. Does not include random genetic screening.

[9] Limited to short-term therapy (two consecutive months) per condition.

[10] Hearing aids and hearing aid testing by an audiologist or hearing aid dealer are not covered, except for recipients age 19-20.

[11] Home health is limited to 100 visits per year. A visit cannot exceed four hours.

[12] Includes ACIP-recommended vaccines

[13] Includes services in a psychiatric unit of a general hospital and inpatient substance abuse detoxification. The ABP does not include inpatient drug rehabilitation services. Free-standing psychiatric hospitals (or Institutions for Mental Disease) are not covered under the ABP or ABP-exempt package except for recipients age 19-20. Surgeries for cosmetic purposes are not covered.

[14] Includes services in a nursing or long-term care acute rehabilitation facility/hospital. Coverage is limited to temporary stays as a step-down level of care from an acute care hospital when medically necessary and the discharge plan for the recipient is the eventual return home.

[15] Transplants are limited to two per lifetime.

Over-the-counter medicines – prenatal drug items and low-dose aspiring as preventive for cardiac conditions[16]
Periodic age-appropriate testing and examinations – glaucoma, colorectal, mammography, pap tests, stool, blood, cholesterol, and other preventive/diagnostic care and screenings[17]
Physician visits
Podiatry and foot care[18]
Prescription medicines
Primary care to treat illness/injury
Pulmonary therapy[19]
Radiation therapy
Reconstructive surgery for the correction of disorders that result from accidental injury, congenital defects or disease
Skilled nursing[20]
Sleep studies[21]
Smoking cessation treatment
Specialist visits
Specialized behavioral health services for adults: Intensive Outpatient Programs (IOP), Assertive Community Treatment (ACT) and Psychosocial Rehabilitation (PSR)[22]
Telemedicine services
Urgent care services/facilities
Vision care for eye injury or disease[23]
Vision hardware (eyeglasses or contact lenses)[24]

[16] Other over-the-counter items may be considered for coverage only when the item is considered more medically or economically appropriate than a prescription drug, contraceptive drug or device, or for treating diabetes.

[17] Includes US Preventive Services Task Force "A" and "B" recommendations, preventive care and screening recommendations of the HRSA Bright Future program and additional preventive services for women recommended by the Institute of Medicine.

[18] Covered when medically necessary due to malformations, injury, acute trauma or diabetes.

[19] Limited to short-term therapy (two consecutive months) per condition.

[20] Subject to the 100-visit home health limited when provided through a home health agency.

[21] Limited to diagnostic sleep studies performed by certified providers/facilities.

[22] The ABP does not cover behavioral health supportive services: Family Support, Recovery Services and Respite services.

[23] Refraction for visual acuity and routine vision are not covered, except for recipients age 19-20.

[24] Covered only following the removal of the lens from one or both eyes (aphakia). Coverage of materials is limited to one set of contact lenses or eyeglasses per surgery, within 90 days following surgery. Vision hardware is covered for recipients age 19-20 following a periodicity schedule.

Section 8 – Medical Management Program and Prior Authorization

Introduction

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

Molina Healthcare may change the process and/or requirements of its Medical Management Program. Changes will be updated in this Provider Manual and a revised version will be uploaded to the website.

Medical Necessity Review

Molina Healthcare only reimburses for services that are Medically Necessary. To determine Medical Necessity, in conjunction with independent professional medical judgment, Molina Healthcare will use nationally recognized guidelines, which include but are not limited to MCG or other third party guidelines, CMS guidelines, state guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks. Medical Necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively.

Medically Necessary means the care which, in the opinion of the treating physician, is reasonably needed to:

- Prevent the onset or worsening of an illness, condition, or disability;
- Establish a diagnosis;
- Provide palliative, curative, or restorative treatment for physical and/or mental health conditions;
- Assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of same age; and
- Not primarily long-term institutional care services unless long-term institutional services are a Covered Service that the Provider has agreed to provide. In addition, there must be no other effective and more conservative or substantially less costly treatment, service and setting available.

Medically Necessary Services means clinical and rehabilitative physical, mental or behavioral health services that are:

1. essential to prevent, diagnose or treat medical conditions or are essential to enable the Member to attain, maintain or regain the Member's optimal functional capacity;
2. delivered in the amount, duration, scope and setting that are both sufficient and effective to reasonably achieve their purposes and clinically appropriate to the specific physical, and behavioral health care needs of the Member;
3. provided within professionally accepted standards of practice and national guidelines;
4. required to meet the physical, and behavioral health needs of the Member; and
5. (not primarily for the convenience of the Member, the provider or Molina Healthcare.

The fact that a provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services Medically Necessary, a Medical Necessity or a Covered Service/Benefit.

Clinical Information

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

Molina Healthcare may request specific clinical information such as clinical notes, consultation reports, imaging studies, lab reports, hospital reports, letters of medical necessity and other clinical information deemed relevant. All requested information will be on a need-to-know, minimum, necessary basis. Molina Healthcare does not require prior authorization for life-threatening, emergency medical or behavioral health conditions.

Prior Authorization

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

- Member demographic information (name, date of birth, Molina Healthcare ID number, etc.);
- Provider demographic information (referring provider and referred to provider/facility);

- Requested service/procedure, including all appropriate CPT, HCPCS and ICD-10 codes; and
- Clinical information sufficient to document the medical necessity of the requested service.

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Federal and State law) are excluded from the prior authorization requirements. Molina Healthcare does not "retroactively" authorize services that require prior authorization.

Molina Healthcare will process any non-urgent requests within fourteen (14) calendar days of receipt of request. Urgent requests will be processed within seventy-two (72) hours of receipt of request.

Providers who request Prior Authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting provider.

Emergency Services

Emergency services are covered on a (24) hour basis without the need for prior authorization for all Members experiencing an emergency medical situation. Molina Healthcare accomplishes this service by providing Utilization Management during business hours and a (24) hour Nurse Triage option on the main telephone line for post business hours. In addition, the 911 information is given to all members at the onset of any call to the plan.

For members within our service area: Molina Healthcare contracts with vendors that provide (24) hour emergency services for ambulance and hospitals. In the event that a Member is outside of the service area, Molina Healthcare is prepared to authorize treatment to ensure that the patient is stabilized.

Requesting Prior Authorization

The prior authorization (PA) process requires a request to determine medical necessity/eligibility before the service is rendered. To expedite the review process, pertinent clinical notes (i.e. practitioner office notes, medication history, lab test results, etc.) should be attached to the PA request. Authorization for a procedure does not in itself guarantee coverage but notifies you that the procedure as described meets criteria for medical necessity and appropriateness.

1. PA Forms and Services / Codes requiring Prior Authorization may be accessed below or on the Molina Healthcare Provider website at http://www.molinahealthcare.com/providers/nm/medicaid/forms/Pages/fuf.aspx

2. Prior Authorization Requests may also be submitted by fax via the following **Toll Free Fax: (888) 802-5711.**

   Pharmacy Prior Authorization Requests may be submitted by fax via the following **Toll Free Fax: (866) 472-4578.**

   Faxes received after 5:00 p.m. Monday through Thursday will be considered to have been received on the next business day. Faxes received after 5:00 p.m. Friday, or on Saturday or Sunday will be considered to have been received on the next business day. Faxes received on a holiday will be considered to have been received on the next business day.

   Medically Urgent Requests by Phone: In Albuquerque: (505) 798-7371 or Toll free (877) 262-0187

3. All authorized services are subject to the Member's benefit plan and eligibility at the time the service is provided. A list of Molina Healthcare's services that require prior authorization are listed below. Routine/Elective requests must be faxed to Molina Healthcare.

   The Prior Authorization/Pre-Service Review Guide and Form, and Codification Matrix are located on the Provider Website at www.molinahealthcare.com

Criteria Used in Making Medically Necessary Decisions

The Molina Healthcare Quality Assurance Committee (QAC) has approved several criteria sets to be utilized for review of service requests. Molina Healthcare utilizes the Office of Disability Guidelines, and internally developed Molina Clinical Policy documents to determine appropriateness of service requests.

If the requested services do not meet criteria for medical necessity or covered services, the case will be referred to a physician reviewer for determination. Molina Healthcare employs physicians licensed in the State of New Mexico to make medical necessity denial decisions for Centennial Care Members. Board certified physicians from appropriate specialty areas will provide consultations as needed for medical necessity decisions.

Denial decisions are communicated to the provider and the Member, in writing, as required by contract and NCQA standards. These letters include the specific utilization review criteria or benefits provisions used in the determination and provide information on the appeal process. Providers have telephonic access to the Medical Director to discuss medical necessity determinations.

Upon request, Molina Healthcare will provide Utilization Management decision criteria to Members, their families and the public.

Second Opinions

As a means of ensuring both high quality health care and Member satisfaction, Molina Healthcare will provide the option for a Member to obtain a second opinion from a qualified health care professional. If an appropriate professional is not available in network, Molina Healthcare will arrange for the Member to obtain the second opinion out of network at no more cost to the Member than if the service was obtained in-network. The Member may obtain a second opinion by:

- Asking his/her PCP for a referral to see another practitioner or specialist to obtain a second opinion medical or surgical services;
- Directly accessing another in-network practitioner; or
- Contacting the Member Services Department in **Albuquerque (505) 342-4681 or toll free (800) 580-2811**, if the practitioner does not agree to a request for a referral for a second opinion.

If a Member requires a second opinion that may only be provided by a practitioner outside the Molina Healthcare network, the referring practitioner will work with Molina Healthcare to obtain the appropriate prior authorization. All out-of-network second opinion requests are reviewed by a Medical Director.

If the practitioner providing the second opinion agrees with the Member's practitioner, Molina Healthcare will not authorize a third opinion. Should the second option differ from the first, the Member may request a third opinion.

The PCP is responsible for coordinating the medical or surgical diagnostic and/or treatment plan if different from the original. The Member's treating behavioral health provider will be responsible for coordinating the behavioral health treatment.

Communication with Providers

Practitioners/providers seeking information about the Utilization Management (UM) process or UM decisions may contact our Health Care Services (HCS) or Pharmacy Management staff between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday. It is Molina Healthcare's policy for staff to identify themselves by name, title and organization when initiating or returning calls regarding UM issues.

Practitioners/providers seeking information regarding medical services may call Provider Services **toll free at (855) 322-4078.** If you would like to discuss a case, please ask to be put in contact with one of Molina Healthcare's Medical staff.

Ensuring Appropriate Service and Coverage/ Avoiding Conflict of Interest

Molina Healthcare does not reward providers or other individuals for issuing denials of coverage or care. Furthermore, Molina Healthcare never provides financial incentives to

encourage authorization decision makers to make determinations that result in under-utilization. Delegated medical groups/IPAs are required to avoid this kind of conflict of interest.

- Decisions about utilization management (effective use of services) are based only on whether care is appropriate and whether a Member has coverage;
- Molina Healthcare does not reward providers or other individuals for issuing denials of coverage or care;
- UM decision-makers do not receive financial incentives, which encourage review decisions that result in underutilization;
- Molina Healthcare does not reward practitioners/providers or other individuals for issuing denials of coverage or service care; and
- UM decisions-makers do not receive financial incentives.

Thirty (30) Day Hospital Readmissions

Definitions:

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

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

Molina Healthcare conducts reviews of acute inpatient admissions that occur within thirty (30) calendar days of a previous initial acute care inpatient admission from the same facility. When such a situation occurs, medical records from the preceding admission will be requested and reviewed in conjunction with clinical documentation from the second admission. If it is determined that the second admission is the result of either premature discharge or of inadequate discharge, transition, or coordination of care, payment for the second admission may be denied. In such instances, please note that the hospital is not allowed to bill the Member.

Hospital readmissions within thirty (30) days have been found by CMS to potentially constitute a quality of care problem. Readmission review is an important part of Molina Healthcare's Quality Improvement Program to ensure that Molina Healthcare members are receiving hospital care that is compliant with nationally recognized guidelines, Medicare regulations, State Medicaid regulations and CMS.

Molina Healthcare will review all hospital subsequent admissions that occur within thirty 30 days of the previous discharge for all Medicaid claims. If the subsequent hospital admission is determined to be a Readmission, Molina Healthcare will deny the subsequent admission or pay for the subsequent admission and seek money from the first Provider if they are different Provider, unless it meets one of the exceptions noted below, violates State and/or Federal law or violates the terms of the Hospital or Provider Services Agreement between the Hospital and Molina.

Exceptions:

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

Timelines for Molina Healthcare Utilization Management Decisions

Type of Request	Molina Decision Timeframes	Molina Notification Timeframes
Non-urgent pre-service decisions (pre-certification routine)	Within 14 calendar days of receipt of request	Within 1 business day of decision
Urgent pre-service Precertification urgent	Within 72 hours of receipt of request **-OR-** Within 1 hour for life threatening conditions	Within 72 hours of receipt of request
Urgent concurrent review (i.e. inpatient, ongoing ambulatory services)	Within 24 hours (equivalent to 1 calendar day) of receipt of request	Within 1 business day of decision
Post-service decisions	Within 30 calendar days of receipt of request	
Residential Services (RTC, TFC, Group Homes)	Within 5 business days of receipt of request	Within 1 business day of decision

Initial Inpatient Admission Review

Elective, Non-Urgent Hospitalizations

1. Prior authorization is required for elective, non-urgent admissions, including admissions for elective procedures;
2. Elective inpatient admission services performed without prior authorization may not be eligible for payment.
3. For elective hospitalizations and procedures requiring overnight hospital stay, the facility needs to fax notification toll free to **(888) 802-5711**on the date of admission; and

4. For hospital stays which exceed any pre-approved number of bed days or level of care, concurrent review of medical necessity is required. Records to support concurrent utilization review must be submitted by fax to **(888) 802-5711** within 24 hours – see "Concurrent Inpatient Admission Review" process below.
5. For elective procedures and for scheduled, non-emergent hospitalizations, please refer to the Prior Authorization Guide above. The request and the relevant clinical information submitted are evaluated and reviewed against established criteria to determine the medical necessity and appropriateness of an inpatient stay and proposed treatment plan.
6. Only patients with a medical need for hospitalization are approved for admission;
7. The proposed treatment is customary for the diagnosis; and
8. Treatment will take place in the most cost effective and appropriate setting.

Urgent/EmergentHospitalizations

1. Molina Healthcare requires notification of all emergent inpatient admissions within twenty-four (24) hours of admission or by the close of the next business day when emergent admissions occur on weekends or holidays. Molina Healthcare requires that notification includes member demographic information, facility information, date of admission and clinical information sufficient to document the medical necessity of the admission. Emergent inpatient admission services performed without meeting notification and medical necessity requirements will result in a denial of authorization for the inpatient admission. The facility/practitioner must fax admission notification toll free to **(888) 802-5711;**
2. All weekend and/or holiday inpatient or hospital observation admissions are subject to retrospective review for medical necessity;
3. For admissions over the weekend/holiday, facility reviews are expected to contain appropriate clinical evidence of services administered over the weekend/holiday;
4. Concurrent utilization review is required for all contracted facilities. Review documentation is to be faxed toll free to **(888) 802-5711** within 24 hours, refer to "Concurrent Inpatient Admission Review" process below;
5. The Medical Director, may call the attending practitioner for more information if questions arise relating to the admission;
6. When coverage is denied based on lack of medical necessity, Molina Healthcare will notify the requesting facility and send a confirmatory denial letter;
7. All medical necessity denials are made by a Molina Medical Director;
8. The attending physician or hospital (with the Member's written consent), the Member or Member's representative may appeal a denial within ninety (90) calendar days; and
9. If the request is of an emergent/urgent nature then the attending physician, hospital, Member or Member's representative can request an expedited appeal.

Labor & Delivery

1. Molina Healthcare does not require notification for "normal" labor and delivery stays (forty- eight (48) hours for vaginal delivery and ninety-six (96) hours for cesarean (C-sections) or for stays less than twenty-four (24) hours. If the newborn is not

discharged with the mother and requires a longer stay, authorization is required; and
2. If the newborn is in a higher acuity bed than newborn nursery, authorization is required.

Notification of Birth (MAD Form 313) must be completed by the hospital (or other Medicaid provider) prior to the time of discharge to ensure that Medicaid eligible newborn infants are enrolled into Centennial Care. The child will be enrolled in the same Managed Care Organization (MCO) as the enrolled mother.

Nursing Facility Admissions /Discharges

Practitioners/Providers are required to promptly notify Molina Healthcare of a:

- Member's admission or request for admission to the Nursing facility regardless of payer source for the Nursing Facility stay;
- Change in a Member's known circumstances; and
- Member's pending discharge (must be in writing).

Concurrent Inpatient Admission Review

Contracted facilities are required to participate in providing documentation to support concurrent utilization review of acute hospital admissions. Documentation supporting medical necessity for hospitalization will be submitted for review by Molina Healthcare HCS staff by no later than twenty-four (24) hours after (1) admission or (2) re-review date as specified by Molina Healthcare HCS staff. Failure to submit such documentation within the specified twenty-four hour (24-hour) timeframe will result in administrative denial of coverage. In such instances, please note that the hospital is not allowed to bill the Member.

Records to support utilization review of initial and ongoing hospital stays should include documentation by the attending physician and other medical professionals providing care for the Member. Appropriate documents for submission include History and Physicals, physician's progress notes, results of pertinent laboratory and imaging studies, vital signs, consultant notes and discharge summaries.

On Site Review

Some facilities may receive on-site review by Molina Healthcare staff. When Healthcare staff Members arrive at your facility, they are required to identify themselves by name, title and organization. They should also be wearing his/her Molina Healthcare photo identification badge.

Non-Contracted Practitioners and Facilities

Molina Healthcare maintains a contracted network of qualified healthcare professionals who have undergone a comprehensive credentialing process in order to provide medical care for Molina Healthcare members. Molina Healthcare requires members to receive medical care within the participating, contracted network of providers. All care provided by non-contracted, non-network providers must be prior authorized by Molina Healthcare. Non-network providers

may provide emergent/urgent care and dialysis 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.

For all admissions to non-contracted facilities, which were not pre-approved through Molina Healthcare, retrospective review is required and documentation is to be submitted at the time of claim submission.

Provider Preventable Conditions and Present on Admission Program

Molina Healthcare follows procedures for coverage of Provider Preventable Conditions as specified by the State of New Mexico and the Centers for Medicare and Medicaid Services. From the State of NM Medical Assistance Program Supplement 12-05:Federal regulations released by the Centers for Medicare and Medicaid Services (CMS) on June 6, 2011 outlined the final requirements regarding *Payment Adjustment for Provider- Preventable Conditions Including Health Care-Acquired Conditions.* These regulations implemented Section 2702 of the Affordable Care Act (ACA, P.L. 111-148 and P.L. 111- 152), which requires the Secretary of Health and Humans Services (HHS) to issue regulations prohibiting federal payments to states for providing medical assistance for Provider Preventable Conditions (PPCs), effective July 1, 2011. The final rule requires that state Medicaid programs implement non-payment polices for provider preventable conditions (PPCs) including health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs).

1. **Provider Preventable Conditions – Hospital-Acquired Conditions**

   One category of PPCs is Hospital Acquired Conditions (HACs), which apply to all inpatient settings. Effective July 1, 2012, the New Mexico Medicaid Program is adopting the CMS present on admission (POA) / Hospital-Acquired Conditions (HAC) policy and will begin to deny claims that indicate that the diagnosis was not present on admission or that the documentation is insufficient to determine if condition was present at the time of inpatient admission. Conditions / diagnosis codes are identified by CMS.

   HACs when not present on hospital admission. The following are conditions or events considered to be HACs:

   a. Foreign Object Retained After Surgery;
   b. Air Embolism;
   c. Blood Incompatibility;
   d. Stage III and IV Pressure Ulcers;
   e. Falls and Trauma; including Fractures, Dislocations, Intracranial Injuries , Crushing Injuries, Burns, Electric Shock;
   f. Catheter-Associated Urinary Tract Infection (UTI);
   g. Vascular Catheter-Associated Infection;
   h. Manifestations of Poor Glycemic Control; including: Diabetic Ketoacidosis, Nonketotic Hyperosmolar Coma, Hypoglycemic Coma, Secondary Diabetes with Ketoacidosis, Secondary Diabetes with Hyperosmolarity; and

i. Surgical Site Infection Following:
   - Coronary Artery Bypass Graft (CABG) – Mediastinitis;
   - Bariatric Surgery; including Laparoscopic Gastric Bypass, Gastroenterostomy, Laparoscopic Gastric Restrictive Surgery;
   - Orthopedic Procedures; including Spine, Neck, Shoulder, Elbow; and
   - Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Total Knee Replacement or Hip Replacement with pediatric and obstetric exceptions.

2. Reporting the Present on Admission Indicator

Practitioners/providers must follow the official POA coding guidelines as set forth in the *UB- 04 Data Specifications Manual* and in the *ICD Official Guidelines for Coding and Reporting*, or their successors. Present on admission is defined as present at the time the order for inpatient admission occurs - conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.

POA indicator is assigned to principal and secondary diagnoses (as defined in Section II of the *Official Guidelines for Coding and Reporting*) and the external cause of injury codes.

Issues related to inconsistent, missing, conflicting or unclear documentation must still be resolved by the provider. If a condition would not be coded and reported based on Uniform Hospital Discharge Data Set definitions and current Official Guidelines, then the POA indicator would not be reported. Providers of inpatient DRG claims will be required to use the "present on admission" indicator on claims for all primary and all secondary diagnoses. If a condition is not present on admission, meaning that it was acquired during the inpatient stay, the New Mexico Medicaid program will not pay for any services or procedures involved in the treatment of that condition. For DRG cases, the DRG payable will exclude the diagnoses not present on admission for any Health-Care Acquired Conditions (HCAC). Claims will be paid as though the diagnosis code is not present.

3. Other Provider Preventable Conditions (OPPC): All Healthcare Providers

The second category of PPCs is Other Provider Preventable Conditions (OPPCs), and applies to all Medicaid enrolled providers including physicians, inpatient and outpatient hospitals, ambulatory surgical centers, and other facilities. OPPCs are conditions occurring in any health care setting that could have reasonably been prevented through the application of evidence based guidelines. Providers are required to report on a claim if an OPPC occurs.

If a provider reports any of the below diagnosis codes on a claim, the reduction in payment will be limited to the amounts directly identifiable as related to the PPC and the resulting treatment. OPPCs are defined as the following (condition with ICD code):

- Performance of wrong operation (procedure) on correct patient;

- Wrong device implanted into correct surgical site excludes: correct operation (procedure) performed on wrong body part;
- Performance of operation (procedure) on patient not scheduled for surgery;
- Performance of operation (procedure) intended for another patient;
- Performance of operation (procedure) on wrong patient;
- Performance of correct operation (procedure) on wrong side/body part;
- Performance of correct operation (procedure) on wrong side; and
- Performance of correct operation (procedure) on wrong site.

Also, if a practitioner/provider reports any one of the below modifiers on a claim, the reduction in payment would be limited to the amounts directly identifiable as related to the OPPC and the resulting treatment.

- PA - Surgery, Wrong Body Part;
- PB - Surgery, Wrong Patient;
- PC – Wrong Surgery on Patient; and
- The New Mexico Medicaid program will continue to follow CMS guidelines and national coverage determinations (NCDs), including any future additions or changes to the current list of HAC conditions, diagnosis codes, and OPPCs.

Practitioners/providers may read more about the Provider Preventable Conditions policy on the CMS website at https://www.medicaid.gov/medicaid/financing-and-reimbursement/provider-preventable-conditions/index.html

Section 9 – Behavioral Health Medical Management Program – Level of Care Guidelines

Medical Necessity Definition

1. Medically necessary services are clinical and rehabilitative physical or behavioral health services that are:

    a. Essential to prevent, diagnose or treat medical conditions or are essential to enable an eligible recipient to attain, maintain or regain functional capacity;
    b. Delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical and behavioral health care needs of the eligible recipient;
    c. Provided within professionally accepted standards of practice and national guidelines; and
    d. Required to meet the physical and behavioral health needs of the eligible recipient and are not primarily for the convenience of the eligible recipient, the provider or the payer.
2. Application of the definition:

    a. A determination that a service is medically necessary does not mean that the service is a covered benefit or an amendment, modification or expansion of a covered benefit, such a determination will be made by the Medical Assistance Division (MAD) or its designee.
    b. The department or its authorized agent making the determination of the medical necessity of clinical, rehabilitative and supportive services consistent with the specific program's benefit package applicable to an eligible recipient will do so by:
        i. evaluating the eligible recipient's physical and behavioral health information provided by qualified professionals who have personally evaluated the eligible recipient within their scope of practice, who have taken into consideration the eligible recipient's clinical history including the impact of previous treatment and service interventions and who have consulted with other qualified health care professionals with applicable specialty training, as appropriate;
        ii. considering the views and choices of the eligible recipient or their personal representative regarding the proposed covered service as provided by the clinician or through independent verification of those views; and
        iii. considering the services being provided concurrently by other service delivery systems
    c. Physical and behavioral health services will not be denied solely because the eligible recipient has a poor prognosis. Required services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible recipient solely because of the diagnosis, type of illness or condition

d. Decisions regarding MAD benefit coverage for eligible recipients under 21 years of age will be governed by the early periodic screening, diagnosis and treatment (EPSDT) coverage rules.

e. Medically necessary service requirements apply to all medical assistance program rules.

Quality of Service Criteria

The following criteria are common to all levels of care for behavioral health conditions and substance use disorders. These criteria will be used in conjunction with criteria for specific level of care.

1. The member is eligible for benefits.
2. The provider completes a thorough initial evaluation, including current assessment information.
3. The member's condition and proposed services are covered under the terms of the benefit plan.
4. The member's current condition can be most efficiently and effectively treated in the proposed level of care.
5. The member's current condition cannot be effectively and safely treated in a lower level of care even when the treatment plan is modified, attempts to enhance the member's motivation have been made, or referrals to community resources or peer supports have been made.
6. There must be a reasonable expectation that essential and appropriate services will improve the member's presenting problems within a reasonable period of time. "Improvement" in this context is measured by weighing the effectiveness of treatment against the evidence that the member's condition will deteriorate if treatment is discontinued in the current level of care. Improvement must also be understood within the framework of the member's broader recovery goals.
7. The goal of treatment is to improve the member's presenting symptoms to the point that treatment in the current level of care is no longer required.
8. Treatment is not primarily for the purpose of providing respite for the family, increasing the member's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.
9. The member has provided informed consent to treatment. Informed consent includes the following:
    a. The member has been informed of safe and effective alternatives.
    b. The member understands the potential risks and benefits of treatment.
    c. The member is willing and able to follow the treatment plan including the safety precautions for treatment.
10. The treatment/service plan stems from the member's presenting condition, and clearly documents realistic and measurable treatment goals as well as the treatments that will

be used to achieve the goals of treatment. The treatment/service plan also considers the following:

a. Use of treatments that are consistent with nationally recognized scientific evidence, prevailing medical standards for the treatment of the member's current condition and clinical guidelines.
b. Significant variables such as the member's age and level of development; the member's preferences, strengths, broader recovery goals and readiness for change; risks including barriers to care; past response to treatment; the member's understanding of his/her condition, its treatment and self-care; and the role that the member's family/social supports should play in treatment with the member's permission
c. Interventions needed to address co-occurring behavioral health or medical conditions.
d. Interventions that will promote the Member's participation in care, promote informed decision-making, and support the member's broader recovery goals. Examples of such interventions are psycho-education, motivational interviewing, recovery planning and use of an advance directive, as well as facilitating involvement with natural and cultural supports, and self-help or peer programs.
e. Involvement of the member's family/social supports in treatment and discharge planning with the member's permission when such involvement is clinically indicated.
f. How treatment will be coordinated with other behavioral health and medical providers as well as within the school system, legal system and community agencies with the member's permission.
g. How the treatment plan will be altered as the member's condition changes, or when the response to treatment is not as anticipated.

11. The discharge plan stems from the member's response to treatment, and considers the following:
    a. Significant variables including the member's preferences, strengths, broader recovery goals and readiness for change; risks including barriers to care; past response to discharge; the member's understanding of his/her condition, its treatment and self-care; and the role that the member's family/social supports should play in treatment with the member's permission.
    b. The availability of a lower level of care, which can effectively and safely treat the member's current clinical condition.
    c. The availability of treatments, which are consistent with nationally, recognized scientific evidence, prevailing medical standards for the treatment of the member's current condition and clinical guidelines.
    d. Involvement of the Member's family/social supports in discharge planning with the member's permission when such involvement is clinically indicated.
    e. How discharge will be coordinated with the provider of post-discharge behavioral health care, medical providers, as well as with the school system, legal system or community agencies with the member's permission.

12. How the risk of relapse will be mitigated including:
    a. Completing and accurate assessment of the member's current level of function and ability to follow through on the agreed upon discharge plan;
    b. Confirming that the member has engaged in shared decision making about the discharge plan and that the member understands and agrees with the discharge plan;
    c. Scheduling a first appointment within 7 days of discharge when care at a lower level is planned;
    d. Assisting the member with overcoming barriers to care (e.g. a lack of transportation or child care challenges);
    e. Ensuring that the member has an adequate supply of medication to bridge the time between discharge and the first scheduled follow-up psychiatric assessment;
    f. Providing psycho-education and motivational interviewing, assisting with recovery planning and use of an advance directive, and facilitating involvement with self-help and peer programs;
    g. Confirming that the member understands what to do in the event that there is a crisis prior to the first post-discharge appointment, or if the member needs to resume services.

13. The availability of resources such natural and cultural supports, such as self-help and peer support programs, and peer-run services, which may augment treatment, facilitate the member's transition from the current level of care, and support the member's broader recovery goals.

Acute Inpatient Hospitalization

1. **Definition of Service:**
   Acute Inpatient Psychiatric Hospitalization is a 24-hour secure and protected, medically staffed, psychiatrically supervised treatment service. This level of care is for stabilization of urgent or emergent behavioral health problems. Acute Inpatient Hospitalization is provided specifically for those members who, as a result of a psychiatric disorder, are an acute and significant danger to themselves or others, or are acutely and significantly disabled, or whose activities of daily living are significantly impaired. This level of care involves the highest level of skilled psychiatric services. It is rendered in a freestanding psychiatric hospital or the psychiatric unit of a general hospital. The care must be provided under the direction of an attending physician who performs a face-to-face interview of the member within 24 hours of admission. The care involves an individualized treatment plan that is reviewed and revised frequently based on the member's clinical status.

   This level of care should not be authorized solely as a substitute for management within the adult corrections, juvenile justice or protective services systems, as an alternative to specialized schooling (which should be provided by the local school system), or simply to serve as respite or housing.

This level of care is available for all age ranges, but admission should be to a unit that is age appropriate. For school age children and youth, academic schooling funded through the local school system or by the facility is expected.

2. Admission Criteria (Meets A and B, and C or D or E or F or G):

a. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in 8.302.1.7 and the member has a DSM diagnosed condition that requires, and is likely to benefit from, the proposed therapeutic intervention.
b. Treatment cannot safely be administered in a less restrictive level of care.
c. There is an indication of actual or potential imminent danger to self that cannot be controlled outside of a 24-hour treatment setting. Examples of indications include serious suicidal ideation or attempts, severe self-mutilation or other serious self-destructive actions.
d. There is an indication of actual or potential imminent danger to others and the impulses to harm others cannot be controlled outside of a 24-hour treatment setting. An example of an indication includes a current threat and means to kill or injure someone.
e. There is an indication of actual or potential grave passive neglect that cannot be treated outside of an acute 24-hour treatment setting.
f. There is disordered or bizarre thinking, psychomotor agitation or retardation, and/or a loss of impulse control or impairment in judgment leading to behaviors that place the member or others in imminent danger. These behaviors cannot be controlled outside of a 24-hour treatment setting.
g. There is a co-existing medical illness that complicates the psychiatric illness or treatment. Together the illnesses or treatment pose a high risk of harm for the member, and cannot be managed outside of a 24-hour treatment setting.

3. Continued Stay Criteria (Meets All):

a. The member continues to meet admission criteria including the need for 24 hour medical supervision.
b. An individualized treatment plan that addresses the member's specific symptoms and behaviors that required Inpatient treatment has been developed, implemented and updated, with the member's and/or guardian's participation whenever possible, which includes consideration of all applicable and appropriate treatment modalities.
c. The member is making meaningful and measurable progress at the current level of care and/or the current or revised treatment plan can be reasonably expected to bring about significant improvements in the behaviors and/or symptoms leading to admission. Progress is documented toward treatment goals.
d. An individualized discharge plan has been developed which includes specific time-limited, realistic, objective and measurable discharge criteria and plans for appropriate follow-up care. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met.

4. **Discharge Criteria (Meets All):**
   a. The member has met his/her individualized discharge criteria.
   b. The member can be safely treated at a less intensive level of care.
   c. An individualized discharge plan with appropriate, realistic and timely follow-up care has been formulated.

5. **Exclusionary Criteria (May Meet Any):**
   a. The condition of primary clinical concern is one of a medical nature (not behavioral health) and, as outlined in the current Mixed Services Protocol, should be covered by another managed care entity.
   b. The member appears to have presented for admission for reasons other than a primary psychiatric emergency, such as homelessness or in appropriate seeking of medications.

Waiting Placement Days (DAP) Rate

1. **Description:**

   Per NMAC 8.321.2.16 Inpatient Days awaiting Placement (DAP) is a negotiated rate used when a Medicaid eligible member no longer meets acute care criteria and it is verified that the eligible member requires a residential level of care which may not be immediately located, those days during which the eligible member is awaiting placement to the lower level of care are termed "awaiting placement days." These circumstances must be beyond the control of the inpatient provider. **DAP is intended to be brief and to support transition to the lower level of care. DAP may not be used solely because the inpatient provider did not pursue or implement a discharge plan in a timely manner.**

2. **Approval Criteria (Must Meet All):**

   a. The member is covered by Medicaid as administered by the Medical Assistance Division definition, and the member has a DSM diagnosed condition that has required an acute inpatient psychiatric level of care currently.
   b. The member no longer meets continued stay criteria for inpatient acute psychiatric care and/or does meet discharge criteria and there is a specific discharge plan in place to a residential level of care, but documented barriers to implementation of that plan exist that are beyond the control of the provider or facility.
   c. The provider has made reasonable efforts to identify and obtain the services needed to implement the discharge plan, and continues to actively work to identify resources to implement that plan.
   d. The MCO has authorized the residential level of care sought as the discharge, and documentation of this authorization has been made available to MCO utilization management personnel.

3. **Exclusionary Criteria:**

a. The member has met his/her individualized discharge criteria and substantial barriers to discharge no longer exist.
b. The inpatient facility cannot demonstrate that it continues to actively work to eliminate barriers to the planned discharge.
c. The inpatient facility is pursuing a discharge to a level of care or service that a MCO psychiatrist peer reviewer has explicitly stated does not appear to meet admission criteria at this time.

23 Hour Observation Stay

This is not a level of care that requires prior authorization but is a level of care that is separate and distinct from psychiatric inpatient level of care.

1. **Definition of Service:**
   A 23 Hour Observation Stay occurs in a secure, medically staffed, psychiatrically supervised facility. This level of care, like acute inpatient hospitalization, involves the highest level of skilled psychiatric services. This service can be rendered in a psychiatric unit of a general hospital, or in the emergency department of a licensed hospital. The care must be provided under the direction of an attending physician who has performed a face-to-face evaluation of the member. The care involves an individual treatment plan that includes access to the full spectrum of psychiatric services. A 23 Hour Observation Stay provides an opportunity to evaluate members whose needed level of care is not readily apparent. In addition, it may be used to stabilize a member in crisis, when it is anticipated that the member's symptoms will resolve in less than 24 hours.

   This level of care may be considered when support systems and/or a previously developed crisis plan have not sufficiently succeeded in stabilizing the member, and the likelihood for further deterioration is high. This level of care is available for all age ranges.

   If a physician orders an eligible recipient to remain in the hospital for less than 24 hours, the stay is not covered as inpatient admission, but is classified as an observation stay. An observation stay is considered an outpatient service.

   The following are exemptions to the general observation stay definition:

   a. The eligible recipient dies;
   b. Documentation in medical records indicates that the eligible recipient left against medical advice or was removed from the facility by his legal guardian against medical advice;
   c. An eligible recipient is transferred to another facility to obtain necessary medical care unavailable at the transferring facility; or
   d. An inpatient admission results in delivery of a child.

If an admission is considered an observation stay, the admitting hospital is notified that the services are not covered as an inpatient admission.

- A hospital must bill these services as outpatient observation services.
- Outpatient observation services must be medically necessary and must not involve premature discharge of an eligible recipient in an unstable medical condition.
- The hospital or attending physician can request a re-review and reconsideration of the observation stay decision.
- The observation stay review does not replace the review of one- and two-day stays for medical necessity.
- Medically unnecessary admissions, regardless of length of stay, are not covered benefits.

2. Admission Criteria (Meets A and B, and C or D or E):

a. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in 8.302.1.7 and the member has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic intervention in less than 24 hours in a secure setting.
b. The member cannot be evaluated in a less restrictive level of care.
c. The member is expressing suicidal ideation or is expressing threats of harm to others that must be evaluated on a continuous basis for severity and lethality.
d. The member has acted in disruptive, dangerous or bizarre ways that require further immediate observation and assessment. An evaluation of the etiology of such behaviors is needed, especially if suspected to be chemically or organically induced.
e. The member presents with significant disturbances of emotions or thought processes that interfere with his/her judgment or behavior that could seriously endanger the member or others if not evaluated and stabilized on an emergency basis.

3. Discharge Criteria (Meets Both):

a. The member no longer meets admission criteria.
b. An individualized discharge plan with appropriate, realistic and timely follow-up care is in place.

4. Exclusionary Criteria (May Meet Any):

a. The member meets admission criteria for Acute Inpatient Hospitalization.
b. The member appears to have presented for admission for reasons other than a primary psychiatric emergency, such as homelessness or in appropriate seeking of medications

F. Accredited Residential Treatment

1. Definition of Service:

Accredited Residential Treatment Center Services (ARTC) is a service provided to members under the age of 21 whom, because of the severity or complexity of their behavioral health needs. These are members who, as a result of a recognized psychiatric disorder(s) are a significant danger to themselves or others. ARTC facilities must be licensed by the New Mexico Department of Children Youth & Family, Licensing and Credentialing Authority (or similar body when located in other states). The need for ARTC services must be identified in the tot to teen health check or other diagnostic evaluation furnished through a Health check referral and the member must meet medical necessity criteria as part of early and periodic screening, diagnosis and treatment (EPSDT) services [42 CFR Section 441.57].

ARTC services are provided in a 24-hour a day/ 7 days a week accredited (The Joint Commission, http://www.jointcommission.org/) facility. Facilities provide all diagnostic and therapeutic services provided. ARTC units are medically staffed at all times with direct psychiatric services provided several days a week and with 24-hour psychiatric consultation availability. The services are provided under the direction of an attending psychiatrist. The treatment plan is reviewed frequently and updated based on member's clinical status. Regular family therapy is a key element of treatment and is required except when clinically contraindicated. Discharge planning should begin at admission, including plans for successful reintegration into the home, school and community. If discharge to a home/family may not be a realistic option, alternative placement/housing must be identified as soon as possible and documentation of active efforts to secure such placement must be thorough.

This service should not be authorized solely as a substitute for management within the juvenile justice or protective services systems, as an alternative to specialized schooling (which should be provided by the local school system) or simply to serve as respite or housing. Academic schooling funded through the local school system or by the facility is expected.

As discussed in NMAC 8.321.2.11 in addition to regularly scheduled structured counseling and therapy sessions (individual, group, family, or multifamily - based on individualized needs, and as specified in the treatment plan), ARTC also includes facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance and money management. ARTC also includes therapeutic services to meet the physical, social, cultural, recreational, health maintenance and rehabilitation needs of recipients that are not primarily recreational or diversional in nature. Also, ARTC will not implement experimental or investigational procedures, technologies, or non-drug therapies or related services.

2. Admission Criteria (Meets All):

a. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in NMAC 8.302.1.7 and the member has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic intervention.
b. The member is experiencing emotional or behavioral problems in the home and/or community to such an extent that the safety or well-being of the member or others is substantially at risk. These problems require a supervised, structured, and 24-hour continuous therapeutic milieu. A licensed behavioral health professional has made the assessment that the member is likely to experience a deterioration of his/her condition to the point that inpatient hospitalization may be required if the individual is not treated at this level of care.
c. Less restrictive or intensive levels of treatment have been tried and shown to be inadequate to meet the member's needs. Documentation exists to support these contentions.

3. Continued Stay Criteria (Meets All):

a. The member continues to meet admission criteria including the need for 24 hour staff supervision
b. The current or revised treatment plan can be reasonable expected to bring about significant improvements or progress to address the goals of treatment. Progress is documented toward treatment goals.
c. The treatment and therapeutic goals are objective, measurable and time-limited to address the alleviation of psychiatric symptoms and precipitating psychosocial stressors.
d. An individualized discharge plan has been developed/updated which includes specific realistic, objective and measurable discharge criteria and plans for appropriate follow-up care within the member's community. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met.
e. An individualized discharge plan has been developed/ updated which includes specific realistic, objective and measurable discharge criteria and plans for appropriate follow-up care within the member's community. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met.
f. The member is actively participating in treatment, and is motivated and engaged in are active that lead to the member's discharge plan.
g. The member's parent(s), guardian or custodian is participating in the treatment and discharge planning,. If parent (s), guardian or custodian are not involved, alternative natural supports need to be identified to engage in treatment and discharge planning

h. Member is making progress in the treatment program. Goals are realistic, targeted, time-limited, and achievable.

4. Discharge Criteria (Meets All):

a. The member has met his/her individualized discharge criteria.
b. The member can be safely treated at a less intensive/restrictive level of care.
c. An individualized discharge plan with linkage to appropriate, realistic and timely follow-up care is in place.

5. Exclusionary Criteria For ARTC: (May Meet Any)

There is evidence (documented) that the ARTC placement is intended as an alternative to incarceration or community corrections involvement, and medical necessity have not been met.

a. There is evidence that the ARTC treatment episode is intended to defer or prolong a permanency plan determination. The inability of unwillingness of a parent or guardian to receive the member back into the home is not grounds for continued ARTC care.
b. The individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.
c. Quality of Service Criteria # 5 has not been met: *The member's current condition cannot be effectively and safely treated in a lower level of care even when the treatment plan is modified, attempts to enhance the member's motivation have been made, or referrals to community resources or peer supports have been made.*
d. Quality of Service Criteria # 8 has not been met: *Treatment is not primarily for the purpose of providing respite for the family, increasing the member's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.*

Sub-Acute Residential Treatment

Not a Value Added Service, and is only available to providers contracted specifically to provide this service.

1. Definition of Service:

Sub-Acute RTC is provided to members under the age of 21 who, because of the severity or complexity of their behavioral health needs, and who require services beyond the scope of the usual Residential Treatment Center Services (RTC) milieu or other out-of-home or community-based treatment services. These are members who, as a result of a recognized psychiatric disorder(s) are a significant danger to themselves or others, but not so acute as to be in need of inpatient hospitalization. Sub-Acute RTC facilities must be licensed by the New Mexico Department of Children Youth & Family, Licensing and Credentialing Authority (or similar body when located in other states). The need for

RTC services must be identified in the tot to teen Healthcheck or other diagnostic evaluation furnished through a Healthcheck referral and the member must meet medical necessity criteria as part of early and periodic screening, diagnosis and treatment (EPSDT) services [42 CFR Section 441.57].

Sub-Acute RTC services are provided in a 24-hour a day/ 7 day a week accredited (The Joint Commission, http://www.jointcommission.org/) facility. Facilities provide all the diagnostic and therapeutic services provided by an RTC, **but with a higher staff to client ratio**. Sub-Acute RTC units are medically staffed at all times with direct psychiatric services provided several days a week and with 24-hour psychiatric consultation availability. The services are provided under the direction of an attending psychiatrist. The treatment plan is reviewed frequently and updated based on member's clinical status. Regular family therapy is a key element of treatment and is required except when clinically contraindicated. Discharge planning should begin at admission, including plans for successful reintegration into the home, school and community. If discharge to a home/family may not be a realistic option, alternative placement/housing must be identified as soon as possible and documentation of active efforts to secure such placement must be thorough.

This service should not be authorized solely as a substitute for management within the juvenile justice or protective services systems, as an alternative to specialized schooling (which should be provided by the local school system) or simply to serve as respite or housing. Academic schooling funded through the local school system or by the facility is expected.

As discussed in NMAC 8.321.2.11 in addition to regularly scheduled structured counseling and therapy sessions (individual, group, family, or multifamily - based on individualized needs, and as specified in the treatment plan), Sub-Acute RTC also includes facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance and money management. Sub-Acute RTC also includes therapeutic services to meet the physical, social, cultural, recreational, health maintenance and rehabilitation needs of recipients that are not primarily recreational or diversional in nature. Also, Sub-Acute RTC will not implement experimental or investigational procedures, technologies, or non-drug therapies or related services.

2. **Admission Criteria (Meets All):**
   a. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in NMAC 8.302.1.7 and the member has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic intervention.
   b. The member is experiencing emotional or behavioral problems in the home and/or community to such an extent that the safety or well-being of the member or others

is substantially at risk. These problems require a supervised, structured, and 24-hour continuous therapeutic milieu. A licensed behavioral health professional has made the assessment that the member is likely to experience a deterioration of his/her condition to the point that inpatient hospitalization may be required if the individual is not treated at this level of care.

c. Less restrictive or intensive levels of treatment have been tried and shown to be inadequate to meet the member's needs. Documentation exists to support these contentions.

3. Continued Stay Criteria (Meets All):

a. The member continues to meet admission criteria including 24 hour staff supervision
b. An individualized treatment plan that addresses the member's specific symptoms and behaviors that required Sub-Acute RTC treatment has been developed, implemented and updated, with the member's or guardian's participation whenever possible, which includes consideration of all applicable and appropriate treatment modalities The treatment and therapeutic goals are objective, measurable and time-limited.
c. The current or revised treatment plan can be reasonable expected to bring about significant improvements or progress to address the goals of treatment. Progress is documented toward treatment goals.
d. An individualized discharge plan has been developed/ updated which includes specific realistic, objective and measurable discharge criteria and plans for appropriate follow-up care. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met.
e. The member is participating in treatment, or there are active efforts being made that can reasonably be expected to lead to the member's engagement in treatment.

The member's parent(s), guardian or custodian is participating in the treatment and discharge planning, or persistent efforts are being made and documented to involve them, unless it is clinically contraindicated.

4. Discharge Criteria (Meets A or B, and C and D):

a. The member has met his/her individualized discharge criteria.
b. The member has not benefited from Sub-Acute Residential Treatment Center
c. Services despite documented persistent efforts to engage the member.
d. The member can be safely treated at a less intensive/restrictive level of care.

An individualized discharge plan with linkage to appropriate, realistic and timely follow-up care is in place.

5. **Exclusionary Criteria For Sub-Acute RTC: (May Meet Any):**
    a. There is evidence (documented) that the Sub-Acute RTC placement is intended as an alternative to incarceration or community corrections involvement, and medical necessity have not been met. There is evidence that the Sub-Acute RTC treatment episode is intended to defer or prolong a permanency plan determination. The inability of unwillingness of a parent or guardian to receive the member back into the home is not grounds for continued Sub-Acute RTC care.
    b. The individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.
    c. The member's current condition cannot be effectively and safely treated in a lower level of care even when the treatment plan is modified, attempts to enhance the member's motivation have been made, or referrals to community resources or peer supports have been made.
    d. Treatment is not primarily for the purpose of providing respite for the family, increasing the member's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.

Residential Treatment Center Services

1. **Definition of Service:**

    Residential Treatment Center Services (RTC), as governed by NMAC 8.321.2.20 (non-accredited RTC) are provided to members under the age of 21 years who require 24-hour treatment and supervision in a safe therapeutic environment.

    Non-Accredited Residential Treatment Centers and Group Homes:

    The New Mexico Medicaid program (Medicaid) pays for medically necessary health services furnished to eligible recipients. To help New Mexico recipients under twenty-one (21) years of age who need the level of care furnished by psychosocial rehabilitation services in a residential setting, the New Mexico Medical Assistance Division (MAD) pays for services furnished in non-accredited residential treatment centers or group homes as part of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services [42 CFR § 441.57]. The need for non-accredited residential treatment center and group home services must be identified in the Tot to Teen Healthcheck screen or other diagnostic evaluation furnished through a Healthcheck referral. This section describes eligible providers, covered services, service limitations, and general reimbursement methodology.

    Provider Responsibilities

    Providers who furnish services to Medicaid recipients must comply with all specified Medicaid participation requirements. See Section MAD-701(8.302.1), GENERAL PROVIDER POLICIES. Providers must verify that individuals are eligible for Medicaid

at the time services are furnished and determine if Medicaid recipients have other health insurance.

Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See Section MAD-701(8.302.1), GENERAL PROVIDER POLICIES. Providers must maintain records documenting the source and amount of nay financial resource collected or receive by provider by behalf of recipients, including federal or state governmental sources and document receipt and disbursement of recipient funds.

Covered Services

Medicaid covers those medically necessary services for recipients under twenty-one (21) years of age which are designed to develop skills necessary for successful reintegration into the family or transition into the community. A level of care determination must indicate that the recipient needs the level of care that is furnished in non-accredited residential treatment centers or group homes. Residential services must be rehabilitative and provide access to necessary treatment services in a therapeutic environment.

The following services must be furnished by centers to receive reimbursement from Medicaid. Payment for performance of these services is included in the center's reimbursement rate:

a. Performance of necessary evaluations and psychological testing for development of the treatment plan, while ensuring that evaluations already performed are not repeated;
b. Regularly scheduled structured counseling and therapy sessions for recipients, groups, families, or multifamily groups based on individualized needs, as specified in the treatment plan;
c. Facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance, and money management;
d. Assistance to recipients in self-administration of medication in compliance with state policies and procedures;
e. Appropriate staff available on a twenty-four (24) hour basis to respond to crisis situations, determine the severity of the situation, stabilize recipients by providing support, make referrals, as necessary, and provide follow-up;
f. Consultation with other professionals or allied care givers regarding a specific recipient;
g. Non-medical transportation services needed to accomplish the treatment objective; and
h. Therapeutic services to meet the physical, social, cultural, recreational, health maintenance, and rehabilitation needs of recipients.

Non-covered Services

Services furnished by non-accredited treatment centers or group homes are subject to the limitations and coverage restrictions which exist for other Medicaid services. See Section MAD-602, GENERAL NONCOVERED SERVICES. Medicaid does not cover the following specific activities furnished in non-accredited residential treatment centers or group homes:

a. Services not considered medically necessary for the condition of the recipients, as determined by MAD or its designee;
b. Room and board;
c. Services for which prior approval was not obtained;
d. Services furnished after the determination is made by MAD or its designee that the recipient no longer needs care
e. Formal educational or vocational services related to traditional academic subjects or vocational training;
f. Experimental or investigations procedures, technologies, or non-drug therapies and related services;
g. Drugs classified as "ineffective" by FDA Drug Evaluations; and
h. Activity therapy, group activities, and other services which are primarily recreational or diversional in nature.

Treatment Plan

An individualized treatment plan used in non-accredited residential treatment centers or group homes must be developed by a team of professionals in consultation with recipients, parents, legal guardians or others in whose care recipients will be released after discharge.

The plan must be developed within fourteen (14) days of the recipient's admission.

a. The interdisciplinary team must review the treatment plan at least every thirty (30) days.
b. The following must be contained in the treatment plan or documents used in the development of the treatment plan. The treatment plan and all supporting documentation must be available for review in the recipient's file:
    i. Statement of the nature of the specific problem and the specific needs of the recipient;
    ii. Description of the functional level of the recipient, including the following:
        - Mental status assessment;
        - Intellectual function assessment;
        - Psychological assessment;
        - Educational assessment;
        - Vocational assessment;
        - Social assessment;
        - Medication assessment; and

- Physical assessment.

iii. Statement of the least restrictive conditions necessary to achieve the purposes of treatment;

iv. Description of intermediate and long-range goals, with the projected timetable for their attainment and the duration and scope of therapy services;

v. Statement and rationale of the plan of treatment for achieving these intermediate and long-range goals, which includes provisions for review and modification of the plan;

vi. Specification of staff responsibilities, description of proposed staff involvement, and orders for medication(s), treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the recipient; and

vii. Criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge, and projected date of discharge.

Admission Criteria (Meets All):

a. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in NMAC 8.305.1, and the member has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic intervention.
b. The member is experiencing emotional or behavioral problems in the home, community and/or treatment setting to such an extent that the safety or well-being of the member or others is at risk. These problems require a supervised, structured, and 24-hour continuous therapeutic milieu in a residential setting.
c. A licensed behavioral health professional has made the assessment that the member is likely to experience a deterioration of his/her condition to the point that a more restrictive treatment setting may be required if the individual is not treated at this level of care at this time.
d. Less restrictive or intensive levels of treatment have been tried and shown to be inadequate to meet the member's needs. Documentation exists to support these contentions.

Continued Stay Criteria (Meets All):

a. The member continues to meet admission criteria including the need for 24 hour staff supervision.
b. An individualized treatment plan that addresses the member's specific symptoms and behaviors that required Residential treatment has been developed, implemented and updated, with the member's or guardian's participation, which includes consideration of all applicable and appropriate treatment modalities. The treatment and therapeutic goals are objective, measurable and time-limited

c. The current or revised treatment plan can be reasonable expected to bring about significant improvements or progress to address the goals of treatment. Progress is documented toward treatment goals.
d. An individualized discharge plan has been developed which includes specific realistic, objective and measurable discharge criteria and plans for appropriate follow-up care within the member's community. A timeline for expected implementation and completion is in place but discharge criteria have not yet been, or other barriers to discharge exist which the provider has made reasonable efforts to mitigate.
e. The member is actively participating in treatment and is motivated and engaged in active efforts to lead to the Member's discharge plan.
f. The member's parent(s), guardian or/or custodian is participating in treatment and discharge planning. If parent(s), guardian or custodian care are not involved, alternative natural supports need to be identified to engage in treatment and discharge planning. Criteria for this is weekly involvement in family therapy, treatment planning and discharge planning
g. Member is making progress in the treatment program. Goals are realistic, targeted, time-limited, and achievable.

Discharge Criteria (Meets A or B, and C and D):

a. The member has met his/her individualized discharge criteria.
b. The member has not realized substantial benefit from Residential Treatment Services despite documented persistent efforts to engage the member.
c. The member can be safely treated at a less intensive/restrictive level of care.
d. An individualized discharge plan with linkage to appropriate, realistic and timely follow-up care is in place.

Exclusionary Criteria for RTC: (May Meet Any):

a. There is evidence that the RTC placement is intended as an alternative to incarceration or community corrections involvement, and medical necessity have not been met.
b. There is evidence that the RTC treatment episode is intended to defer or prolong a permanency plan determination. The inability or unwillingness of a parent or guardian to receive the member back into the home is not grounds for continued RTC care.
c. The individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.
d. The member's current condition cannot be effectively and safely treated in a lower level of care even when the treatment plan is modified, attempts to enhance the member's motivation have been made, or referrals to community resources or peer supports have been made.

e. Treatment is not primarily for the purpose of providing respite for the family, increasing the member's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.

Treatment Foster Care I and II

1. **Definition of Service:**

Treatment Foster Care (TFC), as governed by NMAC 8.321.2.25 and NMAC 8.321.2.26 is a behavioral health service provided to members under the age of 21 years who are placed in a 24-hour community-based supervised, trained, surrogate family through a TFC placement agency licensed by the New Mexico Department of Children Youth & Family, Licensing and Credentialing Authority.

NMAC citation 8.322.2/ MAD citation 745.1 TREATMENT FOSTER CARE Level I and Level II: The New Mexico Medicaid program (Medicaid) pays for medically necessary health services furnished to eligible recipients. The New Mexico Medical Assistance Division (MAD) pays for mental health services furnished to recipients under twenty-one (21) years of age who have an identified need for treatment foster care and meet this level of care as part of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services [42 CFR § 441.57]. The need for treatment foster care services must be identified in the Tot to Teen HealthCheck or other diagnostic evaluation furnished through a HealthCheck referral. This section describes eligible providers, covered services, service limitations, and general reimbursement methodology.

Provider Responsibilities Providers who furnish services to Medicaid recipients must comply with all specified Medicaid participation requirements. See Section MAD-701, GENERAL PROVIDER POLICIES. Providers must verify that individuals are eligible for Medicaid at the time services are furnished and determine if Medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services provided to recipients. See Section MAD-701, GENERAL PROVIDER POLICIES. Providers must maintain records documenting the source and amount of any financial resource collected or receive by provider by behalf of recipients, including federal or state governmental sources and document receipt and disbursement of recipient funds.

Covered Services

Medicaid covers those services included in individualized treatment plans which are designed to help recipients develop skills necessary for successful reintegration into the natural family or transition into the community.

a. The family living experience is the core treatment service to which other individualized services can be added. Treatment foster parents are employed or contracted by the treatment foster care agency. Their responsibilities include:
    i. Participation in the development of treatment plans for recipients by providing input based on their observations;
    ii. Assumption of primary responsibility for implementing the in-home treatment strategies specified in a treatment plan;
    iii. Recording information and documentation of activities, as required by the foster care agency and the standards under which it operates;
    iv. Helping recipients maintain contact with their families and enhancement of those relationships;
    v. Supporting efforts specified by the treatment plan to meet the recipient's permanency planning goals; and
    vi. Assisting recipients obtain medical, educational, vocational, and other services to reach goals identified in treatment plans.
b. The following services must be furnished by the agency certified for treatment foster care to receive reimbursement from Medicaid. Payment for performance of these services is included in the provider's reimbursement rate:

    i. Assessment of the recipient's progress in TFC and assessment of family interactions and stress;
    ii. Regularly scheduled counseling and therapy sessions for recipients in individual, family, or group sessions;
    iii. Facilitation of age-appropriate skill development in the areas of household management, nutrition, physical and emotional health, basic life skills, time management, school attendance, money management, independent living, relaxation techniques, and self-care techniques;
    iv. Crisis intervention, including twenty-four (24) hour availability of appropriate
    staff to respond to crisis situations; and
    v. When a return to the natural family is planned, assessment of family strengths and needs and development of a family service plan.

Non-covered Services

Treatment foster care services are subject to the limitations and coverage restrictions which exist for other Medicaid services. See Section MAD-602, GENERAL NON-COVERED SERVICES. Medicaid does not cover the following services:

a. Room and Board;
b. Formal educational or vocational services related to traditional academic subjects or vocational training; and
c. Respite care.

Treatment Plan

The treatment plan must be developed by the treatment team in consultation with recipients, families or legal guardians, physicians, if applicable, and others in whose care recipients will be released after discharge. The plan must be developed within fourteen (14) days of a recipient's admission to the TFC program.

a. The treatment team must review the treatment plan every thirty (30) days.
b. The following must be contained in the treatment plan or documents used in the development of the treatment plan. The treatment plan and all supporting documentation must be available for review in the recipient's file:
    i. Statement of the nature of the specific problem and the specific needs of the recipient;
    ii. Description of the functional level of the recipient, including the following:
        - Mental status assessment;
        - Intellectual function assessment;
        - Psychological assessment;
        - Educational assessment;
        - Vocational assessment;
        - Social assessment;
        - Medication assessment; and
        - Physical assessment.
    iii. Statement of the least restrictive conditions necessary to achieve the purposes of treatment;
    iv. Description of intermediate and long-range goals, with the projected timetable for their attainment and the duration and scope of therapy services;
    v. Statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including provisions for review and modification of the plan;
    vi. Specification of staff and TFC parent responsibilities, description of proposed staff involvement, orders for medication(s), treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the recipient; and
    vii. Criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge, and projected date of discharge.

NMAC citation 322.5/ MAD citation 745.5 TREATMENT FOSTER CARE (LEVEL II): The New Mexico Medicaid program (Medicaid) pays for medically necessary health services furnished to eligible recipients. The New Mexico Medical Assistance Division (MAD) pays for mental health services furnished to recipients under twenty-one (21) years of age who have an identified need for treatment foster care and meet this level of care as part of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services [42 CFR § 441.57]. The need for treatment foster care

services must be identified in the Tot to Teen HealthCheck or other diagnostic evaluation furnished through a HealthCheck referral. This section describes eligible providers, covered services, service limitations, and general reimbursement methodology. [11-1-99]

Provider Responsibilities

Providers who furnish services to Medicaid recipients must comply with all specified Medicaid participation requirements. See Section MAD-701 (8.302.1), GENERAL PROVIDER POLICIES. Providers must verify that individuals are eligible for Medicaid at the time services are furnished and determine if Medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services provided to recipients. See Section MAD-701 (8.302.1), GENERAL PROVIDER POLICIES. Providers must maintain records documenting the source and amount of any financial resource collected or received by the provider on behalf of recipients, including federal or state governmental sources and document receipt and disbursement of recipient funds. [11-1-99]

Covered Services

Treatment Foster Care II is a mental and behavioral health treatment modality provided by a specially trained treatment foster care parent or family in his or her or their home. Treatment parents are employed by or contracted for and trained by a TFC agency certified by The New Mexico Children, Youth and Families Department (CYFD). TFC II combines the normalizing influence of family-based care with individualized treatment interventions and social supports, thereby creating a therapeutic environment in the family context or maintaining and extending an existing therapeutic context established in TFC. Through the provision of TFC II services, the child's symptoms are expected to decrease and functional level to improve or maintain so that he or she may be discharged successfully to a less restrictive setting, that best meets the child's needs. Medicaid covers those services included in the individualized treatment plan which are designed to help recipients develop skills necessary for successful reintegration into the biological, foster or adoptive family or transition to the community. TFC II will allow for a step-down from TFC when the child improves and no longer meets those utilization review criteria. TFC II will also allow entry into the program at a lower level of care for those children who would benefit optimally from the treatment foster care model.

a. The therapeutic family living experience is the core treatment service to which other individualized services can be added. Treatment foster parents are employed or contracted by the treatment foster care agency. Their responsibilities include:

    i. Participation in the development of treatment plans for recipients by providing input based on their observations;
    ii. Assumption of primary responsibility for implementing the in-home treatment strategies as specified in an individualized treatment plan;

iii. Recording of information and documentation of all activities required by the foster care agency and the standards under which it operates;
iv. Helping recipients maintain contact with their families and fostering enhancement of those relationships as appropriate;
v. Supporting efforts specified by the treatment plan to meet the recipient's permanency planning goals; and
vi. Through coordinating, linking and monitoring services, assist recipients to obtain medical, educational, vocational, and other necessary services to reach goals identified in the treatment plan.

b. The following services must be performed by the agency or be contracted for and overseen by the agency certified for treatment foster care to receive reimbursement from Medicaid.

i. Assessment of the recipient and his biological, foster or adoptive family's strengths and needs;
ii. Development of a discharge plan that includes a strengths and needs assessment of the recipient's family when a return to that family is planned, including a family service plan;
iii. Development and monitoring of the treatment plan;
iv. Assessment of the recipient's progress in TFC II;
v. Assessment of the TFC II family's interaction with the recipient, his or her biological, foster or adoptive family, and any stressors identified;
vi. Facilitation of age-appropriate skills development in the areas of household management, nutrition, physical, behavioral and emotional health, basic life skills, social skills, time management, school and/or work attendance, money management, independent living skills, relaxation techniques, and self-care techniques;
vii. Ensuring the occurrence of counseling or therapy sessions for recipients in individual, family and/or group sessions as specified in the treatment plan; and
viii. Ensuring the availability of crisis intervention, including twenty-four (24) hour a day, seven (7) days a week) availability of appropriately licensed parties to respond to crisis situations. [11-1-99]

Non-covered Services

Treatment foster care services are subject to the limitations and coverage restrictions which exist for other Medicaid services. See Section MAD-602, GENERAL NONCOVERED SERVICES. Medicaid does not cover the following services:

a. Room and Board;
b. Formal educational or vocational services related to traditional academic subjects or vocational training; and
c. Respite care. [11-1-99]

Treatment Plan

The treatment plan must be developed by the treatment team in consultation with the recipient, his or her biological, foster or adoptive family or legal guardian, physician(s), when applicable, and others in whose care the recipient is involved and/or in whose care to whom the recipient will be released after discharge. The plan must be developed within fourteen (14) days of a recipient's admission to the TFC II program.

a. The treatment coordinator must review the treatment plan every thirty (30) days.
b. The following must be contained in the treatment plan or documents used in the development of the treatment plan. The treatment plan and all supporting documentation must be available for review in the recipient's file:
    i. Statement of the nature of the specific problem and the specific needs and strengths of the recipient;
    ii. Description of the functional level of the recipient, including the following:
        - Mental status assessment;
        - Intellectual function assessment;
        - Psychological assessment;
        - Educational assessment;
        - Vocational assessment;
        - Social assessment;
        - Medication assessment; and
        - Physical assessment.
    iii. Statement of the least restrictive conditions necessary to achieve the purposes of treatment;
    iv. Description of intermediate and long-range goals with the projected timetable for their attainment;
    v. Statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including provisions for review and modification of the plan;
    vi. Specification of staff and TFC II parent responsibilities and the description and frequency of the following components: proposed staff involvement, orders for medication(s), treatments, restorative and rehabilitative services, activities, therapies, social services, special diet, and special procedures recommended for the health and safety of the recipient; and
    vii. Criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge, and projected date of discharge. [11-1-99]

2. Admission Criteria (Meets A, B, E, and C or D):

**These admission criteria are for both TFC I and II, with some caveats, as noted below.*

a. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in NMAC 8.305.1, and the member has a

DSM diagnosed condition that requires, and is likely to benefit from, therapeutic interventions implemented in a TFC/ family living experience treatment setting.

b. The member's current (within 30 days of proposed admission) medical and psychiatric symptoms require and can be managed safely in a 24-hour supervised community/home-based setting.
c. The member is immediately at risk for needing a higher level of services and/or being excluded from community, home or school activities due to clinically significant disruptive symptoms or behaviors. These symptoms or behaviors are not amenable to treatment in the member's own home or a standard foster care environment.
d. A licensed behavioral health professional has made the assessment that the member is likely to experience a deterioration of his/her condition to the point that a more restrictive treatment setting may be required if the individual is not treated at this level of care at this time.
e. Less restrictive or intensive levels of treatment have been tried and shown to be inadequate to meet the member's needs. Documentation exists to support these contentions.

For <u>TFC I</u> the following additional admission criteria must be met:

The member is unable to participate independently (without 24-hour adult supervision) in age appropriate activities.

For <u>TFC II</u> the following additional admission criteria must be met:

The member has met the treatment goals of TFC I or is able to participate independently in age appropriate activities without 24-hour adult supervision.

Additionally, to be appropriate for TFC II, the member's treatment needs or social, behavioral, emotional, or functional impairments are not as serious or severe as those exhibited by members who meet criteria for TFC I; therefore services are less clinically intensive than those provided in TFC I. Members in TFC II can generally participate independently in age appropriate activities (e.g. dressing self at age 7, working at age 16, attending school without parental classroom supervision), while members in TFC I could require supervision for those activities. TFC II is often, but not always, used as a transition from TFC I; members may be admitted directly to TFC II. Conversely, <u>not all members in TFC I need to go to TFC II before discharge from TFC.</u>

3. Continued Stay Criteria (Meets All):

a. The member continues to meet all relevant admission criteria.
b. The member continues to need 24-hour adult supervision and/or assistance to develop, restore or maintain skills and behaviors that are necessary to live safely in their own home and community.
c. An individualized treatment plan that addresses the member's specific symptoms and behaviors that required TFC treatment has been developed, implemented and

updated according to licensing rules, with the member's and/or legal guardian's participation, which includes consideration of all applicable and appropriate treatment modalities. The treatment and therapeutic goals are objective, measurable and time-limited.

d. The current or revised treatment plan can be reasonable expected to bring about significant improvements or progress to address the goals of treatment. Progress is documented toward treatment goals.
e. An individualized discharge plan has been developed (and updated since the last clinical review/approval) which includes specific realistic, objective and measurable discharge criteria and plans for appropriate follow-up care. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met.
f. The member is participating in treatment, or there are active, persistent efforts being made that can reasonably be expected to lead to the member's engagement in treatment.
g. The parent, legal guardian or custodian is participating in the treatment, discharge and/or permanency planning, or persistent efforts are being made and documented to involve them, unless it is clinically indicated otherwise.

4. Criteria for Transition From TFC I to TFC II (Meets All):

a. A review of the individualized treatment and permanency plan shows that the member has met a significant portion of all TFC I treatment goals.
b. Continued stay in a treatment foster care setting is necessary to maintain the gains made in TFC I, but member does not require the intensity of supervision associated with TFC I.
c. The member is able to participate independently in age appropriate activities without continuous adult supervision.

5. Discharge Criteria (Meets A or B, and C and D):

a. The member has met his/her individualized discharge criteria.
b. The member has not benefited from Treatment Foster Care despite documented persistent efforts to engage the member.
c. The member can be safely treated at a less intensive level of care.
d. An individualized discharge plan with appropriate, realistic and timely follow-up care is in place.

6. Exclusionary Criteria for TFC I AND TFC II (May Meet Any):

a. There is evidence that the TFC placement is intended as an alternative to incarceration or community corrections involvement, and medical necessity have not been met.
b. There is evidence that the TFC treatment episode is intended to defer or prolong a permanency plan determination, or is substituting for permanent housing.
c. The individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.
d. Quality of Service Criteria: The member's current condition cannot be effectively and safely treated in a lower level of care even when the treatment plan is modified, attempts to enhance the member's motivation have been made, or referrals to community resources or peer supports have been made.
e. Quality of Service Criteria Treatment is not primarily for the purpose of providing respite for the family, increasing the member's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.

Group Home

1. **Definition of Service:**
   Group Home is a lower level of care than Residential Treatment Center Services and is indicated when a structured home-based living situation is unavailable or not clinically appropriate for the member's behavioral health needs and the member needs services focused on psychosocial skills development. Group Home services also differ from Treatment Foster Care in that they are residentially and group based, rather than family and community based.

   NMAC citation 321.4 /MAD citation 742.3 NON-ACCREDITED RESIDENTIAL TREATMENT CENTERS AND GROUP HOMES:

   The New Mexico Medicaid program (Medicaid) pays for medically necessary health services furnished to eligible recipients. To help New Mexico recipients under twenty-one (21) years of age who need the level of care furnished by psychosocial rehabilitation services in a residential setting, the New Mexico Medical Assistance Division (MAD) pays for services furnished in non-accredited residential treatment centers or group homes as part of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services [42 CFR § 441.57]. The need for non-accredited residential treatment center and group home services must be identified in the Tot to Teen HealthCheck screen or other diagnostic evaluation furnished through a HealthCheck referral. This section describes eligible providers, covered services, service limitations, and general reimbursement methodology.

   Provider Responsibilities

Providers who furnish services to Medicaid recipients must comply with all specified Medicaid participation requirements. See Section MAD-701, GENERAL PROVIDER POLICIES. Providers must verify that individuals are eligible for Medicaid at the time services are furnished and determine if Medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See Section MAD-701, GENERAL PROVIDER POLICIES. Providers must maintain records documenting the source and amount of nay financial resource collected or receive by provider by behalf of recipients, including federal or state governmental sources and document receipt and disbursement of recipient funds.

Covered Services

Medicaid covers those medically necessary services for recipients under twenty-one (21) years of age which are designed to develop skills necessary for successful reintegration into the family or transition into the community. A level of care determination must indicate that the recipient needs the level of care that is furnished in non-accredited residential treatment centers or group homes. Residential services must be rehabilitative and provide access to necessary treatment services in a therapeutic environment. The following services must be furnished by centers to receive reimbursement from Medicaid. Payment for performance of these services is included in the center's reimbursement rate:

a. Performance of necessary evaluations and psychological testing for development of the treatment plan, while ensuring that evaluations already performed are not repeated;
b. Regularly scheduled structured counseling and therapy sessions for recipients, groups, families, or multifamily groups based on individualized needs, as specified in the treatment plan;
c. Facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance, and money management;
d. Assistance to recipients in self-administration of medication in compliance with state policies and procedures;
e. Appropriate staff available on a twenty-four (24) hour basis to respond to crisis situations, determine the severity of the situation, stabilize recipients by providing support, make referrals, as necessary, and provide follow-up;
f. Consultation with other professionals or allied care givers regarding a specific recipient;
g. Non-medical transportation services needed to accomplish the treatment objective; and
h. Therapeutic services to meet the physical, social, cultural, recreational, health maintenance, and rehabilitation needs of recipients.

Non-covered Services

Services furnished by non-accredited treatment centers or group homes are subject to the limitations and coverage restrictions which exist for other Medicaid services. See Section MAD-602, GENERAL NONCOVERED SERVICES. Medicaid does not cover the following specific activities furnished in non-accredited residential treatment centers or group homes:

a. Services not considered medically necessary for the condition of the recipients, as determined by MAD or its designee;
b. Room and board;
c. Services for which prior approval was not obtained;
d. Services furnished after the determination is made by MAD or its designee that the recipient no longer needs care
e. Formal educational or vocational services related to traditional academic subjects or vocational training;
f. Experimental or investigations procedures, technologies, or non-drug therapies and related services;
g. Drugs classified as "ineffective" by FDA Drug Evaluations; and
h. Activity therapy, group activities, and other services which are primarily recreational or diversional in nature.

Treatment Plan

An individualized treatment plan used in non-accredited residential treatment centers or group homes must be developed by a team of professionals in consultation with recipients, parents, legal guardians or others in whose care recipients will be released after discharge. The plan must be developed within fourteen (14) days of the recipient's admission.

a. The interdisciplinary team must review the treatment plan at least every thirty (30) days.
b. The following must be contained in the treatment plan or documents used in the development of the treatment plan. The treatment plan and all supporting documentation must be available for review in the recipient's file:
    i. Statement of the nature of the specific problem and the specific needs of the recipient;
    ii. Description of the functional level of the recipient, including the following:
        - Mental status assessment;
        - Intellectual function assessment;
        - Psychological assessment;
        - Educational assessment;
        - Vocational assessment;
        - Social assessment;
        - Medication assessment; and
        - Physical assessment.

iii. Statement of the least restrictive conditions necessary to achieve the purposes of treatment;
iv. Description of intermediate and long-range goals, with the projected timetable for their attainment and the duration and scope of therapy services;
v. Statement and rationale of the plan of treatment for achieving these intermediate and long-range goals, which includes provisions for review and modification of the plan;
vi. Specification of staff responsibilities, description of proposed staff involvement, and orders for medication(s), treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the recipient; and
vii. Criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge, and projected date of discharge.

2. Admission Criteria (Meets A, B and C, and either D or E):

a. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in NMAC 8.305.1, and the member has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic intervention.
b. The member may manifest significant psychological or behavioral disturbances but can participate in age-appropriate community based activities (including school) with assistance from group home staff or with other support.
c. Less restrictive or intensive levels of treatment have been tried and shown to be inadequate to meet the member's needs. Documentation exists to support these contentions.
d. A structured home-based living situation is unavailable or is not appropriate for the member's needs.
e. The member is in need of 24-hour therapeutic milieu, but does not require the intensive staff assistance that is provided in Residential Treatment Center Services.

3. Continued Stay Criteria (Meets All):

a. The member continues to meet admission criteria.
b. The member continues to need 24-hour supervision and assistance to develop or restore skills and behaviors that are necessary to live safely in the home and community.
c. An individualized treatment plan that addresses the member's specific symptoms and behaviors that required Group Home treatment has been developed, implemented and updated, with the member's and/or guardian's participation whenever possible, which includes consideration of all applicable and appropriate treatment modalities. The treatment and therapeutic goals are objective, measurable and time-limited

d. The current or revised treatment plan can be reasonable expected to bring about significant improvements or progress to address the goals of treatment. Progress is documented toward treatment goals
e. An individualized discharge plan has been developed which includes specific realistic, objective and measurable discharge criteria and plans for appropriate follow-up care. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met.
f. The member is participating in treatment, or there are active, persistent efforts being made that can reasonably be expected to lead to the member's engagement in treatment.
g. The parent, guardian or custodian is participating in the treatment, discharge and/or permanency planning, or persistent efforts are being made and documented to involve them, unless it is clinically indicated otherwise.

4. Discharge Criteria (Meets A or B, and C and D):

a. The member has met his/her individualized discharge criteria.
b. The member has not benefited from Group Home services despite documented persistent efforts to engage the member.
c. The member can be safely treated at a less intensive level of care
d. An individualized discharge plan with appropriate, realistic and timely follow-up care is in place.

5. Exclusionary Criteria (May Meet Any):

a. There is evidence that the Group Home placement is intended as an alternative to incarceration or community corrections involvement, and medical necessity have not been met.
b. There is evidence that the Group Home treatment episode is intended to defer or prolong a permanency plan determination. The inability of unwillingness of a parent or guardian to receive the member back into the home is not grounds for continued Group Home care.
c. The individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.
d. MCO Quality of Service Criteria # 5 has not been met: The member's current condition cannot be effectively and safely treated in a lower level of care even when the treatment plan is modified, attempts to enhance the member's motivation have been made, or referrals to community resources or peer supports have been made.
e. MCO Quality of Service Criteria # 8 has not been met: Treatment is not primarily for the purpose of providing respite for the family, increasing the member's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.

Applied Behavior Analysis (ABA)

1. **Definition of Service:**
   ABA services are provided to a Medical Assistance Programs (MAP) eligible member 12 months up to 21 years of age. A member's eligibility for ABA service falls into one of two categories: "At Risk for Autism Spectrum Disorder (ASD)" or "Diagnosed with ASD." An eligible member must meet the level of care (LOC) Criteria detailed below, which includes medically necessary criteria.

   Medically necessary services

   a. Medically necessary services are clinical and rehabilitative physical or behavioral health services that:
      i. are essential to prevent, diagnose or treat medical conditions or are essential to enable an eligible member to attain, maintain or regain functional capacity;
      ii. are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical and behavioral health care needs of the eligible member;
      iii. are provided within professionally accepted standards of practice and national guidelines; and
      iv. are required to meet the physical and behavioral health needs of the eligible member and are not primarily for the convenience of the eligible member, the provider or the payer.
   b. Application of the definition:
      i. A determination that a service is medically necessary does not mean that the service is a covered benefit or an amendment, modification or expansion of a covered benefit, such a determination will be made by MAD or its designee.
      ii. The department or its authorized agent making the determination of the medical necessity of clinical, rehabilitative and supportive services consistent with the specific program's benefit package applicable to an eligible member will do so by:
         - evaluating the eligible member's physical and behavioral health information provided by qualified professionals who have personally evaluated the eligible member within their scope of practice, who have taken into consideration the eligible member's clinical history including the impact of previous treatment and service interventions and who have consulted with other qualified health care professionals with applicable specialty training, as appropriate;
         - considering the views and choices of the eligible member or their personal representative regarding the proposed covered service as provided by the clinician or through independent verification of those views; and
         - considering the services being provided concurrently by other service delivery systems.

iii. Physical and behavioral health services will not be denied solely because the eligible member has a poor prognosis. Required services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible member solely because of the diagnosis, type of illness or condition
iv. Decisions regarding MAD benefit coverage for eligible members under 21 years of age will be governed by the early periodic screening, diagnosis and treatment (EPSDT) coverage rules.
v. Medically necessary service requirements apply to all medical assistance program rules.

2. Admission Criteria for Diagnosed with ASD and At-Risk for ASD (Must meet A-G for admission):

a. Services are determined to be medically necessary per NMAC 8.302.1.7.
b. The eligible member cannot adequately participate in home, school, or community activities because the presence of behavioral excesses (i.e. socially significant behaviors) and/or the absence of functional skills interfere with meaningful participation in these activities; and/or
c. The eligible member presents a safety risk to self or others. (The presence of safety risk to self or others does not need to meet the threshold criteria for out-of-home placement.)
d. There is a reasonable expectation that ABA services will result in measurable improvement in the acquisition of functional, adaptive skills, and/or the reduction of non-functional, maladaptive behavior.
e. The eligible member's caregivers are able to participate and commit meaningfully to ABA interventions and activities to be conducted outside the formal treatment environment.
f. The eligible member follows the prescribed three-stage comprehensive approach to evaluation, assessment, and treatment as outlined in the MAD ABA Billing Instructions.
g. The eligible member meets one of the following two categories:
    i. *At-risk for ASD*: eligible A member may be considered At-Risk for ASD, and therefore eligible for time-limited, Focused ABA Services if he or she does not meet full criteria for ASD per the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD), and when he or she meets all of the following criteria:
        - Is between 12 and 36 months of age;
        - Presents with developmental differences and/or delays as measured by standardized assessment;
        - Demonstrates some characteristics of the disorder (e.g., impairment in social communication and early indicators for the development of restricted and repetitive behavior);
        - Presents with at least one genetic risk factor (e.g., the eligible member has genetic risk due to having an older sibling with a well-documented

medical diagnosis of ASD; the eligible member has a diagnosis of Fragile X syndrome).

ii. *Diagnosed with ASD:* An eligible member 12 months up to 21 years of age who has a medical diagnosis of ASD according to the latest DSM or ICD criteria is eligible for ABA services if the evaluation leading up to a diagnosis of ASD meets service requirements as stated in NMAC 8.321.2 (10.C*) Covered services -stage 1*.

iii. When a member has been diagnosed with ASD within the last 12 months by an in-state or out-of-state provider who meets Stage 1 provider requirements, an ICD may be developed.

3. Continued Eligibility Criteria (Must meet A through C, or both A and D for continuation):

a. The eligible member continues to meet the ABA admission criteria.
b. There is evidence the child, family, and social supports can continue to participate effectively in this service.
c. The eligible member responds positively to ABA services, as evidenced by quantitative data submitted by the ABA Provider (AP) when requesting prior authorization for continuation of ABA services.
d. When the eligible member does not respond positively to ABA services, as evidenced by quantitative data and clinical information submitted by the ABA Provider (AP) when requesting prior authorization for continuation of ABA services, the treatment plan and the treatment plan report (i.e., graphs, peer review) must be updated to reflect what interventions will be changed to produce measurable gains.

4. Discharge Criteria (Must meet one of A-D for discharge):

Individualized discharge criteria are developed with appropriate, realistic, and timely follow-up care and these criteria are included in the initial or most current ABA Treatment Plan. An eligible member may be discharged from ABA services when any of the following are present:

a. The eligible member has met his or her individualized discharge criteria.
b. The eligible member has reached the defining age limit as specified for At-Risk for ASD eligibility which is up to 3 years of age, or for Diagnosed with ASD eligibility which is under 21 years of age.
c. The eligible member can be appropriately treated at a less intensive level of care.
d. The eligible member requires a higher level of care, which includes out-of-home placement.

Note: Out-of-home placement would not include treatment foster care because ABA services could continue at that level of care.

5. **Exclusionary Criteria (Must meet one of A-F for exclusion):**
   An eligible member may be excluded from ABA services when any of the following are present:

   a. The eligible member's Comprehensive or Targeted Diagnostic Evaluation or the ISP and/or Treatment Plan Updates recommend placement in a higher, more intensive, or more restrictive LOC (Not to include treatment foster care: See note in Section III.).
   b. The eligible member's provider, such as psychiatrist, recommends higher LOC.
   c. The eligible member is in an out-of-home placement (Not to include treatment foster care: See note in Section III). An exception is that time limited ABA services may be authorized while the member remains in the out-of-home facility for transition when ABA services are approved to be rendered upon his or her discharge from the facility to a community ABA provider.
   d. The referral for the Comprehensive Diagnostic Evaluation did not follow the Eligibility requirements defined in 8.321.2 Section 10(B).
   e. The member has reached the maximum age for ABA services.
   f. Family/caregiver is unable to participate in the treatment plan.

Value-Added Services

The following services / benefits are offered by Molina Healthcare and are not mandatory covered services.

L. Electroconvulsive Therapy (ECT)

1. Service Description:

For use as a treatment for severe depression that has not responded to other treatment. Short-term ECT is given for a limited number of times per week for a limited number of weeks. Maintenance ECT is provided as required; maintenance ECT is provided less frequently than short-term ECT, i.e. once per week/two weeks/month. Short-term ECT & Maintenance ECT is typically for adults but will evaluate for pediatric population on a case-by-case basis.

2. Criteria for Approval (Must meet all):

a. Medical necessity has been demonstrated according to the member's clinical needs and the member has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic intervention.
b. A second opinion from a psychiatrist confirms that ECT is an appropriate treatment for the member.
c. A medical evaluation indicates no contraindication for ECT.
d. Informed consent for ECT has been obtained and documented in the treatment record.

e. The member has treatment resistant depression or psychotic disorder, is experiencing a severe or prolonged manic episode unresponsive to usual treatments, cannot tolerate usual psychotropic medications, exhibits food refusal leading to nutritional compromise or is experiencing such intense suicidal ideation that there is an urgent need for response, or it is the member's choice for treatment.

3. Criteria for Maintenance Electroconvulsive Therapy (Must Meet All):

a. The member meets the criteria for approval for ECT as outlined above, received ECT, and had a positive response.
b. Other treatment options are not viable for the member.
c. A second opinion from another (other than the current treating psychiatrist) is obtained every 6 months documenting the need for maintenance ECT.

Infant Mental Health (IMH)

1. Service Description:

Infant Mental Health Services (IMH) targets children (0-5) in distress or with clear symptoms indicating a mental health disorder. IMH address problems with attachment and relationships in families, focus on the parent-child relationship, and are designed to improve infant and family functioning in order to reduce risk for more severe behavioral, social, emotional, and relationship disturbances as infants get older. Relationship-focused interventions to the parents, foster parents, or other primary caregivers with infants and toddlers.

2. Criteria for Approval ((Must Meet All):

A. Before engaging in IMH Treatment Services, the infant must have a comprehensive treatment file containing the following:
   i. One infant mental health diagnostic evaluation.
   ii. One individualized service plan that includes IMH Treatment Services as an intervention.

B. At least 80% of IMH services need to be provided *in vivo* in the home or other settings natural to the infant and family.

C. Infant/parent psychotherapy must be provided by an endorsed level 3 or 4 infant mental health specialist.

D. In addition, providers of this service must have the capacity to:
   i. Coordinate with other children's serving systems to address the infant and caregiver's concrete, developmental and environmental needs; and
   ii. Provide guidance to parents/caregivers with information and strategies that address an infant's social and emotional capacities, as well as parental/caregiver strengths.

Section 10 – Care Management / Care Coordination

Care Management / Care Coordination Overview

Molina Healthcare's Integrated Care Management, which includes Utilization Management, Case Management (known as Care Coordination under the Centennial Care Program), and Disease Management, will work with providers to assist with coordinating services and benefits for members with complex needs and issues. It is the responsibility of contracted providers to assess members and with the participation of the member and their representatives, create a treatment care plan. The treatment plan is to be documented in the medical record and is updated as conditions and needs change.

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

Molina Healthcare recognizes the emotional impact the diagnosis of a serious or catastrophic illness can have on their patients. Molina Healthcare has a Care Management/Care Coordination program that can help providers better manage patients' health. The Health Care Services Department has the clinical experience that enables us to respond quickly to patient needs. This clinical experience helps us coordinate care for many different illnesses and conditions, including, but not limited to:

- Acute Diseases;
- Behavioral Health Diagnoses including Substance Abuse that adversely affects the patient's life;
- Progressive arthritic conditions;
- Cancer;
- Congestive Heart Failure;
- Dependent child in out-of-home placements;
- Dementias/deteriorating cognitive abilities;
- Epilepsy;
- High-risk pregnancies;
- Hospital readmissions within thirty (30) days;
- ICF/MR/DD;
- Medically fragile;
- Muscular/neuromuscular degenerative diseases; and
- Transplants.

Practitioners/providers must contact the Molina Care Manager/Care Coordinator should any of the following conditions occur:

- Inability to contact Member;
- Inability to provide services;
- Change in the Member's condition;
- Member unexpectedly leaves their place of residence or without notification;
- Member is transferred to the hospital;
- Member suffers a fall;
- Skin integrity issues;
- Hospice election;
- Bed hold and therapeutic leave requests (Skilled Nursing Facilities only); and
- Death of the Member.

The earlier you provide notification of these cases, the sooner Molina Healthcare can begin working with you to maximize the patient's health coverage benefits. Members can be referred to Molina Healthcare for Care Coordination by telephone or fax via the following:

Complex Medical Care Management/Care Coordination Review toll free fax: (866) 472-4575

Care Coordination/ Care Management Referral Forms can be accessed via the Molina Healthcare Provider Portal at: ***Care Coordination Form***

A. Role of the Care Manager/Care Coordinator

Molina Healthcare provides care coordination that includes the following functions:

- Performs a Health Risk Assessment (HRA) that determines the need for a Comprehensive Needs Assessment (CNA) ;
- If HRA determines a need for a CNA, the in-person, (meaning in the Member's home) assessment is scheduled and completed.
- If the CNA indicates Member would benefit from care coordination, and Member agrees, the member is assigned to Care Management/Care Coordination Level 2 or 3, with 3 being assigned to Members with complex health care needs;
- The CNA aids in determining the Member's physical and behavioral health, and long-term care needs;
- With the Member, the Care Manager/Care Coordinator develops and updates a Comprehensive Care Plan based upon the Member's individual needs and preferences; and
- Provision of on-going coordination services based upon Member's assessed need.

The PCP serves as the point of initial contact and as the Member's "medical home." In addition to the PCP, other practitioners/providers are included in the care management/ care coordination process. Specialists, therapists, home and community-based providers, subcontractors and other practitioners/providers – including those that are out-of-network – are included in the Interdisciplinary Care Team, as appropriate, and provide input into the development of the Member's treatment plan or ISP and care planning process.

Care Managers/Care Coordinators work with these practitioners/providers to coordinate services and provide updates on the results of Member assessments. Practitioners/providers should contact the Member's Care Manager/Care Coordinator or the Member's PCP if they detect a change in the Member's condition by calling the Care Coordination Unit **(855) 315-5677.**

Primary care teams consisting of residents and a supervising faculty physician for contracts with teaching facilities or teams which include certified mid-level practitioners who, at the Member's request, may serve as the point of first contact. Molina Healthcare will organize its team to ensure continuity of care to Members and will identify a "lead physician" within the team for each Member. The "lead physician" will be an attending physician (medical students, interns and residents may not serve as "lead physician").

The Member plays a critical role in Molina's Care Management Model. Self-management support helps the Member understand how medical, behavioral, social, and cultural influences drive decisions regarding healthcare.

Molina Healthcare has in place several initiatives to promote continuity and coordination of services. These activities incorporate processes that occur at various stages of the health care continuum as well as addressing changes in the status of the Member. These processes include, but are not limited to:

- Evaluation of continuity and coordination of care, including reevaluation upon a change in condition;
- Coordination of all medical care;
- Coordination of care between behavioral health and medical care;
- Continuity after practitioner termination;
- Member notification of PCP and specialist termination;
- Continuity of care upon new Member effective date of enrollment; and
- Continuity of care following Member loss of eligibility.

Coordinating Medical Services

Care Managers/Care Coordinators' primary responsibilities are assessing and facilitating services to include:

- Connecting Members with their PCP;
- Identifying need for social determinants and facilitate engagement with Community Health Workers (CHW)
- Reviewing the need for Long Term Services and Supports.

Providers may request care coordination for their Molina Members.

Section 11 – Disease / Health Management

Molina Healthcare provides health management services to at-risk Members who have asthma, diabetes, chronic obstructive pulmonary disease (COPD), and cardiovascular disease (CVD). Molina Healthcare is in the process of developing additional health management programs to meet the needs of Members with Behavioral Health diagnoses and Members receiving LTSS.

Molina Healthcare's health management programs are designed to assist your patients who have chronic health conditions better understand his/her condition, update him/her on new information about the condition and provider him/her with assistance. Additionally, all identified Members will receive periodic educational newsletters.

motherhood matters^{sm} **Pregnancy Program**

Molina Healthcare also offers a voluntary educational program for pregnant Members. Molina Healthcare cares about the health of your pregnant patients and their new babies. You can take advantage of better support and care for your patients when you refer your pregnant patients to our ***motherhood matters***^{sm} Pregnancy Program. Your patients will be given additional education, guidance and resources.

Members enrolled in the ***motherhood matters***^{sm} Pregnancy Program receive a free infant car seat for completing the prenatal education and car seat safety education program. They also receive a free convertible (toddler) car seat for completing a postpartum check-up within three (3) to eight (8) weeks after delivery of their newborn.

Call Molina Healthcare's Health Improvement hotline **toll free at (800) 377-9594** to refer a patient or for more information regarding this program. This information is also available on Molina Healthcare's website at www.molinahealthcare.com

Pregnancy Notification Diagnosis Reimbursement

Molina Healthcare continues to offer ***additional reimbursement*** to providers for pregnancy notification. When you diagnose a Molina Healthcare Member with a confirmed pregnancy you can receive a $100 notification incentive. **Please use ICD-10 Z32.01 (Encounter for pregnancy test, result positive)** when submitting notification and claim for reimbursement.

Prenatal Visit and Postpartum Visit Incentive

Molina Healthcare also provides ***additional reimbursement*** to providers for up to thirteen (13) prenatal visits and a postpartum visit preferably within three (3) to eight (8) weeks after delivery.

Prenatal Care: Receive $30 for each visit, up to thirteen (13) visits:

- CPT II code 0500F – Initial prenatal care visit; and
- CPT II code 0502F – Subsequent prenatal visits.

Postpartum Care: Receive $30 for postpartum visit:

- CPT II code 0503F.

If you have any questions, please call Provider Services toll free at (855) 322-4078, Monday through Friday between 8:00 a.m. and 5:00 p.m.

17 Hydroxyprogesterone Caproate (17P)

Molina Healthcare enhances this program by ***offering a $500 incentive*** to your office whenever you administer a complete course of 17P for members deemed to be at risk for preterm delivery, as determined by a practitioner.

- **Eligibility for incentive if Member has completed:** 1) all injections ordered, 2) at least 98% of injections ordered, 3) required injections through pregnancy, or 4) fetal demise.
- **Incentive ineligibility:** Non-compliant members.

When a practitioner requests 17P directly from Molina, staff will order it and have it sent directly to your office from the compounding pharmacy, Vasco Rx. **If another source of 17P is utilized, please inform us.**

- Vasco Phone #: (602) 971-6950, Option 5 Vasco Fax #: (602) 404-2504
- Molina Contact: (800) 377-9594 ext. 186336

Manage Your Chronic Disease (MyCD) Program

Molina Healthcare has an evidence-based lifestyle change program for Members with a chronic health condition such as diabetes, asthma, high blood pressure, heart disease, etc. The Chronic Disease Self-Management Program (CDSMP)/Manage Your Chronic Disease (MyCD) Program can help people gain the self-confidence necessary to take part in maintaining their health and managing their chronic health condition.

The ***MyCD Program*** was developed by Stanford University. Results of their research earned the program as "evidence-based" due to predictably positive results for those participants who attended regularly. This peer-led education program is delivered in community settings such as senior centers, community centers, churches, libraries and hospitals. The program is for adults of all ages with chronic conditions. Family, friends and caregivers are also welcome.

Classes are held in small groups and meet for 2½ hours, once (1) a week for six (6) weeks. The highly interactive workshops are led by pairs of trained leaders, most of who have a chronic condition themselves and may have successfully adopted the techniques taught in the program. The workshops cover skill-building techniques to deal with challenges such as:

- Frustration, fatigue, pain and isolation;
- Appropriate exercise for maintaining and improving strength,
- Flexibility and endurance;
- Appropriate use of medications;

- Communicating effectively with health professionals, family and friends; and
- Eating healthy.

Molina Healthcare practitioners/providers play a powerful role in the success of this program. Patients have stated that receiving a referral from their provider would be the most powerful motive to join the program.

To register Molina Healthcare Members for the MyCD Program call Molina Healthcare's Health Improvement Hotline toll free at (800) 377-9594, or (505) 342-4660 in Albuquerque.

National Diabetes Prevention Program (NDPP)

Molina Healthcare has another FREE lifestyle change program called the National Diabetes Prevention Program. This evidence-based program is from the Centers for Disease Control and Prevention (CDC). The program is available for Members who are risk for diabetes (pre diabetes). The program is a 16-week lifestyle change program that helps lower Members' risk for type 2 diabetes through learning healthy changes, increasing physical activity and losing weight. Coaching sessions meet weekly for 16 weeks. After the 16 weeks, the sessions meet monthly for six (6) months for additional support. To qualify for this program, Members must be at least 18 years of age AND have one of the following: BMI of 24 or higher (22 or higher for Asian), elevated fasting or two (2) hour glucose tolerance, HbA1C (5.7 – 6.4) glucose levels, a history of gestational diabetes and/or family history of diabetes.

To refer Molina Healthcare Members for the NDPP classes, call Molina Healthcare's Health Improvement Hotline toll free at (800) 377-9594, extension 182618 or (505) 342-4660, extension 182618 in Albuquerque.

Medication Therapy Management Program (MTM)

Molina Healthcare in collaboration with the University of New Mexico College of Pharmacy Medication Therapy Management Center offers Members the services of pharmacists by appointment to assist with their medication issues. Appointments are available by phone or office visit. Referrals are suggested for Members with medication adherence problems who want to learn about how and why their medication therapy is important. Referrals can be made by contacting the Molina Healthcare Pharmacy Management Department at (855) 322-4078 extension 186336.

Section 12 – Pharmacy Management

Formulary (Preferred Drug List)

The development and maintenance of the Molina Healthcare formulary, or Preferred Drug List (PDL) is overseen by the Molina Healthcare Pharmacy and Therapeutics (P&T) Committee, the mission of which is to ensure access to the medications and treatments that meet or exceed established standards for the delivery of quality care. This committee meets quarterly and is comprised of physicians and pharmacists from within the company as well as contracted providers.

The purpose of the PDL is to assist in maintaining the quality of patient care by providing a range of safe and effective medications to the Members. The Molina Healthcare formulary is classified as a closed formulary, which necessitates requests for prior authorization (PA) related to drugs not listed on the formulary. Contracted providers are requested to refer to the Molina Healthcare of New Mexico PDL when selecting prescription drug therapy for eligible plan Members. The PDL may be accessed and printed via the Molina Healthcare website via the following link: Molina Healthcare Formulary . Paper copies of the Molina Healthcare PDL may also be obtained by calling the Member Service Department in **Albuquerque at (505) 341-7493**.

The New Mexico Universal Drug Prior Authorization Request Form may be downloaded for fax via this link - Drug Prior Authorization Form

Specialty Pharmaceuticals - Injectables and Infusion Services

Many self-administered and office-administered injectable products require Prior Authorization (PA). In some cases, they will be made available through one of Molina's exclusive specialty pharmacies – either Accredo Specialty Pharmacy or Caremark Specialty Pharmacy. More information about our Prior Authorization process, including a PA request form, is available in Section 6 of this manual.

Accredo or Caremark will coordinate with Molina and ship the prescription directly to your office or the Member's home. All packages are individually labeled 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 the Pharmacy Management Department or your Provider Relations Representative with any further questions about the program.

Non-Formulary Requests for Specialty/ Injectable Medication

These medications generally require a prior authorization or are managed in terms of the number of doses allowed in a given time span. When requesting a prior authorization for injectable medications, complete a copy of the New Mexico Universal Drug Prior Authorization Request Form (See Section A above) and fax it to Molina Healthcare Pharmacy Management

Department in **Albuquerque toll free number (866) 472-4578.** Please include all pertinent medical necessity documentation that justifies the use of a non-formulary medication as well as the expected duration of therapy. Molina Healthcare will review the request and evaluate it according to established guidelines. The resulting decision will be communicated to both the prescriber and the Member.

Approved injections supplied by and administered in a practitioner's office should be billed electronically or on a CMS-1500 form.

Non-Formulary Requests for Oral Medications

Complete the New Mexico Universal Drug Prior Authorization Request Form – Medication Prior Request Form and fax it to the Molina Healthcare Pharmacy Management Department in Albuquerque at the **toll free number (866) 472-4578.** Please include all pertinent medical necessity documentation that justifies the use of a non-formulary medication as well as the expected duration of therapy. Molina Healthcare will review the request and evaluate it according to established guidelines. The resulting decision will be communicated to both the prescriber and the Member.

Formulary Addition Requests From Practitioners

We value and want your feedback. Molina Healthcare, Inc. convenes a Pharmacy & Therapeutics (P&T) Committee to review formulary changes. The committee is composed of Molina staff and actively practicing, contracted physicians of various specialties and pharmacists.

To request a Formulary Addition, please download the request form at this link – Formulary Addition Request Form Please fax it to Molina Healthcare in **Albuquerque at (505) 348-0299.** The P&T Committee will review the request as soon as possible and communicate its decision to the requesting practitioner.

Medicare Part D Pharmacy Benefit

Dual Eligible Molina Healthcare Members (Members enrolled in both Medicare and Medicaid) will receive their primary pharmacy coverage through Medicare Part D. Molina Healthcare will provide wrap-around prescription drug coverage for selected Medicaid members that are on medications in drug classes not covered through Medicare Part D (mostly non-prescription drugs). By law, Medicaid cannot cover drugs not covered by Medicare because they are non-formulary or for which prior authorization was denied nor are Medicare Part D copayments covered. Medicare Prescription Drug coverage is available through the Members Medicare Advantage Prescription Drug Plans (MA-PD and standalone Prescription Drug Plans (PDP).

Medicare Part D is a built-in benefit. Members participating in Molina's Medicare Special Needs Plan (SNP) called "Options Plus" automatically receive Medicare Part D coverage. There are no forms to fill out or selections to make. Molina handles the paperwork for all Members participating in the Molina Medicare SNP.

Section 13 – Credentialing / Recredentialing

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

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 of Quality Assurance (NCQA). The Credentialing Program is reviewed annually, revised, and updated as needed.

Definitions

A Rental/Leased Network - a network of Providers that leases its panel to another network or insurer with an emphasis on expanding Provider access and negotiating discounted fee-for-service fees. This type of network is sometimes referred to as a brokerage-leased network or thought of as "wholesale," since Members' access to the network is through an intermediary.

Primary Care Practitioner (PCP) – a Provider who has the responsibility for supervising, coordinating, and providing primary health care to Members, initiating referrals for specialist care, and maintaining the continuity of Member care. PCPs include, but are not limited to Pediatricians, Family Providers, General Providers or Internists, as designated by Molina.

General Practitioner – Physicians who are not Board Certified and have not completed a training program from an accredited training program in their requested specialty.

Urgent Care Provider (UCP) - a Provider who is not a PCP and only provides urgent care services to Members. Urgent care services are medically necessary services, which are required for an illness or injury that would not result in further disability or death if not treated immediately, but require professional attention and have the potential to develop such a threat if treatment is delayed longer than 24 hours. A UCP may include PA, NP, MD and DO. The UCP is usually trained in general practice, internal medicine, family medicine, pediatrics, or emergency medicine. Some UCPs may also have specialty training.

Primary Source verification - the process by which Molina verifies credentialing information directly from the entity that originally conferred or issued the credential to the Provider.

Locum Tenens – a substitute physician used to fill in for a regular physician for reasons such as illness, pregnancy, vacation, or continuing medical education. The regular physician bills and receives payment for the substitute physician as though he/she performed them. The substitute physician generally has no practice of his/her own and moves from area to area as needed. The regular physician generally pays the substitute physician a fixed amount per diem, with the substitute physician having the status of an independent contractor rather than of an employee.

Physician – is a Doctor of Medicine (MD) or Doctor of Osteopathy (DO)

Unprofessional conduct - refers to a basis for corrective action or termination involving an aspect of a Provider's competence or professional conduct, which is reasonably likely to be detrimental to Patient safety or the delivery of quality care. Unprofessional conduct does not refer to instances where a Provider violates a material term of the Provider's contract with a Molina plan.

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 Providers for participation in the Molina network. This policy defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the Molina network. To remain eligible for participation Providers must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Molina. These criteria and the sources used to verify these criteria are listed in the table below.

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

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

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
Application Provider must submit to Molina a complete, signed and dated credentialing application. The application must be typewritten or completed in non-erasable ink. Application must include all required attachments. The Provider must sign and date the application attesting their application is complete and correct within one-hundred-eighty (180) calendar days of the credentialing decision. **If the Provider's attestation exceeds one-hundred-eighty (180) days before the credentialing decision, the Provider must attest that the information on the application remains correct and complete, but does not need to complete another application. It is preferred to send a copy of the completed application with the new attestation form when requesting the Provider to update the attestation.** If Molina or the Credentialing Committee requests any additional information or clarification, the Provider must supply that information in the period requested. Any changes made to the application must be initialed and dated by the Provider. Whiteout may not be used on the application rather the incorrect information must have a line drawn through it with the correct information	▪ Every section of the application is complete or designated N/A ▪ Every question is answered ▪ The attestation must be signed and dated within one-hundred-eighty (180) calendar days of credentialing decision ▪ All required attachments are present ▪ Every professional question is clearly answered and the page is completely legible ▪ A detailed written response is included for every yes answer on the professional questions	All Provider types	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
written/typed and must be initiated and dated by the Provider. If a copy of an application from an entity external to Molina is used, it must include an attestation to the correctness and completeness of the application. Molina does not consider the associated attestation elements as present if the Provider did not attest to the application within the required period of one-hundred-eighty (180) days. If State regulations require Molina to use a credentialing application that does not contain an attestation, Molina must attach an addendum to the application for attestation. The application and/or attestation documents cannot be altered or modified.				
License, Certification or Registration Provider must hold an active, current 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. If a Provider has ever had his or her professional license/certification/registration in any State suspended or revoked or Provider has ever surrendered, voluntarily or involuntarily, his or her professional license/certification/registration in any State while under or to avoid investigation by the State or due to findings by the State resulting from the Provider's acts, omissions or	Verified directly with the appropriate State licensing or certification agency. This verification is conducted by one of the following methods: ▪ On-line directly with licensing board ▪ Confirmation directly from the appropriate State agency. The verification must indicate: ▪ The scope/type of license ▪ The date of original licensure ▪ Expiration date ▪ Status of license ▪ If there have been, or currently are, any disciplinary action or sanctions on the	All Provider types who are required to hold a license, certification or registration to practice in their State	Must be in effect at the time of decision and verified within One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
conduct, Molina will verify all licenses, certifications and registrations in every State where the Provider has practiced.	license.			
DEA or CDS certificate Provider must hold a current, valid, unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Provider must have a DEA or CDS in every State where the Provider provides care to Molina Members. If a Provider has a pending DEA/CDS certificate because of just starting practice or because of moving to a new State, the Provider may be credentialed on "watch" status provided that Molina has a written prescription plan from the Provider. This plan must describe the process for allowing another Provider with a valid DEA/CDS certificate to write all prescriptions requiring a DEA/CDS number. If a Provider has never had any disciplinary action taken related to his/her DEA or CDS and chooses not to have a DEA or CDS certificate, the Provider may be considered for network participation if they submit a prescription plan for another Provider with a valid DEA or CDS certificate to write all prescriptions. If a Provider does not have a DEA because it has been revoked, restricted or relinquished due to disciplinary reasons, the Provider is not eligible to	DEA or CDS is verified by one of the following: ▪ On-line directly with the National Technical Information Service (NTIS) database. ▪ On-line directly with the U.S. Department of Justice Drug Enforcement Administration, Office of Diversion Control ▪ Current, legible copy of DEA or CDS certificate ▪ On-line directly with the State pharmaceutical licensing agency, where applicable Written prescription plans: ▪ A written prescription plan must be received from the Provider. It must indicate another Provider with a valid DEA or CDS certificate to write all prescriptions requiring a DEA number. ▪ Molina must primary source verify the covering Providers DEA.	Physicians, Oral Surgeons, Nurse Providers, Physician Assistants, Podiatrists	Must be in effect at the time of decision and verified within one-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
participate in the Molina network.				
Education & Training Providers will only be credentialed in an area of practice in which they have adequate education and training as outlined below. Therefore, Providers must confine their practice to their credentialed area of practice when providing services to Molina Members.	As outlined below under Education, Residency, Fellowship and Board Certification.	All Provider Types	Prior to credentialing decision	Initial & Recredentialing
Education Provider must have graduated from an accredited school with a degree required to practice in their specialty.	The highest level of education is primary source verified by one of the following methods: ▪ Primary source verification of Board Certification as outlined in the Board Certification section of this policy. ▪ Confirmation from the State licensing agency when Molina has documentation that the State agency conducts primary source verification of the highest level of education and this confirmation is not greater than 12-months old. ▪ The American Medical Association (AMA) Physician Master File. This verification must indicate the education has specifically been verified. ▪ The American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File. This verification must indicate the education	All Provider types	Prior to credentialing decision	Initial Credentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
	has specifically been verified. ▪ Confirmation directly from the accredited school. This verification must include the type of education, the date started, date completed and if the Provider graduated from the program. ▪ Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986. ▪ Association of schools of the health professionals, if the association performs primary-source verification of graduation from medical school and Molina has written confirmation from the association that it performs primary source verification of graduation and this confirmation is not greater than twelve (12) months old. ▪ If a physician has completed education and training through the AMA's Fifth Pathway program, this must be verified through the AMA. ▪ Confirmation directly from the National Student Clearing House. This verification must include the name of the accredited school, type of education and dates			

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
	of attendance.			
Residency Training Provider must have satisfactorily completed a residency program from an accredited training program in the specialty in which they are practicing. Verification of the residency is always required except for General Providers as described in the General Provider section below. Molina only recognizes residency 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 have completed 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.	Residency Training is primary source verified by one of the following methods: ▪ Primary source verification of current or expired board certification in the same specialty of the Residency Training program (as outlined in the Board Certification section of this policy). ▪ The American Medical Association (AMA) Physician Master File. This verification must indicate the training has specifically been verified. ▪ The American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File. This verification must indicate the training has specifically been verified. ▪ Confirmation directly from the accredited training program. This verification must include the type of training program, specialty of training, the date started, date completed and if the program was successfully completed. ▪ Association of schools of the health professionals, if the association performs primary-source verification of residency training and Molina has written	Oral Surgeons, Physicians, Podiatrists	Prior to credentialing decision	Initial Credentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
	confirmation from the association that it performs primary source verification of graduation and this confirmation is not greater than twelve (12) months old. ▪ For Closed Residency Programs, residency completion can be verified through the Federation of State Medical Boards Federation Credentials Verification Service (FCVS). ▪ For podiatrists, confirmation directly from the Council of Podiatric Medical Education (CPME) verifying podiatry residency program. This verification must include the type of training program, specialty of training, the date started, date completed and if the program was successfully completed.			
Fellowship Training If the Provider is not board certified in the specialty in which they practice and has not completed a residency program they must have completed a fellowship program from an accredited training program in the specialty in which they are practicing. When a Provider has completed a Fellowship, Molina always completes either a verification of Board Certification or Verification of Residency in addition to the verification of Fellowship	Fellowship Training is primary source verified by one of the following methods: ▪ Primary source verification of current or expired Board Certification in the same specialty of the Fellowship Training program (as outlined in the Board Certification section of this policy). ▪ The American Medical Association (AMA) Physician Master File. This verification must indicate the training has specifically been	Physicians	Prior to credentialing decision	Initial Credentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
to meet the NCQA requirement of verification of highest level of training.	verified. ▪ The American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File. This verification must indicate the training has specifically been verified. ▪ Confirmation directly from the accredited training program. This verification must include the type of training program, specialty of training, the date started, date completed and if the program was successfully completed.			
Board Certification Board certification in the specialty in which the Provider is practicing is preferred but not required. Initial applicants who are not board certified may be considered for participation 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	Board certification is primary source verified through one of the following: ▪ An official ABMS (American Board of Medical Specialties) display agent, where a dated certificate of primary-source authenticity has been provided (as applicable). ▪ AMA Physician Master File profile (as applicable). ▪ AOA Official Osteopathic Physician Profile Report or AOA Physician Master File (as applicable). ▪ Confirmation directly from the board. This verification must include the specialty of the certification(s), the original certification date, and the expiration	Dentists, Oral Surgeons, Physicians, Podiatrists	Must be in effect at the time of decision and verified within One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
(ABPM) ▪ American Board of Oral and Maxillofacial Surgery ▪ American Board of Addiction Medicine (ABAM) Molina must document the expiration date of the board certification within the credentialing file. If the board certification does not expire, Molina must verify a lifetime certification status and document in the credentialing file. American Board of Medical Specialties Maintenance of Certification Programs (MOC) –Board certified Providers that fall under the certification standards specified that board certification is contingent upon meeting the ongoing requirements of MOC, no longer list specific end dates to board certification. Molina will list the certification as active without an expiration date and add the document in the credentialing file.	date. ▪ On-line directly from the American Board of Podiatric Surgery (ABPS) verification website (as applicable). ▪ On-line directly from the American Board of Podiatric Orthopedic and Primary Medicine (ABPOPM) website (as applicable). ▪ On-line directly from the American Board of Oral and Maxillofacial Surgery website www.aboms.org (as applicable). ▪ On-line directly from the American Board of Addiction Medicine website https://www.abam.net/find-a-doctor/ (as applicable).			
General Practitioner Providers who are not board certified and have not completed a training program from an accredited training program are only eligible to be considered for participation as a general Provider in the Molina network. To be eligible, the Provider must have maintained a primary care practice in good standing for a minimum of the most recent five years without any gaps in work history.	The last five years of work history in a PCP/General practice must be included on the application or curriculum vitae and must include the beginning and ending month and year for each work experience. Any gaps exceeding six months will be reviewed and clarified either verbally or in writing. Verbal communication will be appropriately documented in the credentialing file. A gap in work history that	Physicians	One-hundred-eighty (180) Calendar Days	Initial Credentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
Molina will consider allowing a Provider who is/was board certified and/or residency trained to participate as a general Provider, if the Provider is applying to participate in one of the following specialties : ▪ Primary Care Physician ▪ Urgent Care ▪ Wound Care	exceeds 1 year will be clarified in writing directly from the Provider.			
Advanced Practice Nurse Providers Advanced Practice Nurse Providers must be board certified or eligible to become board certified in the specialty in which they are requesting to practice. Molina recognizes Board Certification only from the following Boards: ▪ American Nurses Credentialing Center (ANCC) ▪ American Academy of Nurse Providers Certification Program (AANP) ▪ Pediatric Nursing Certification Board (PNCB) ▪ National Certification Corporation (NCC)	Board certification is verified through one of the following: ▪ Confirmation directly from the board. This verification must include the specialty/scope of the certification(s), the original certification date, and the expiration date. ▪ Current copy of the board certification certificate including the specialty/scope of the certifications(s), the original certification date and the expiration date ▪ On-line directly with licensing board, if the licensing primary verifies a Molina recognized board certification. License must indicate board certification/scope of practice. ▪ Provider attests on their application to board certification including the specialty/scope of the certifications(s), the original certification date and the expiration date.	Nurse Providers	One-hundred-eighty (180) Calendar Days	Initial and Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
Physician Assistants Physician Assistants must be licensed as a Certified Physician Assistant. Physician Assistants must also be currently board certified or eligible to become board certified the National Commission on Certification of Physician Assistants (NCPPA).	Board certification is primary source verified through the following: ▪ On-line directly from the National Commission on Certification of Physician Assistants (NCPPA) website https://www.nccpa.net/.	Physician Assistants	One-hundred-eighty (180) Calendar Days	Initial and Recredentialing
Providers Not Able To Practice Independently In certain circumstances, Molina may credential a Provider who is not licensed to practice independently. In these instances it would also be required that the Provider providing the supervision and/or oversight be contracted and credentialed with Molina. Some examples of these types of Providers include: ▪ Physician Assistants ▪ Nurse Providers	▪ Confirm from Molina's systems that the Provider providing supervision and/or oversight has been credentialed and contracted.	Nurse Providers, Physician Assistants and other Providers not able to practice independently according to State law	Must be in effect at the time of decision and verified within One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
Work History Provider must supply a minimum of 5-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If the Provider has practiced fewer than 5-years from the date of Credentialing, the work history starts at the time of initial licensure. Experience practicing as a non-physician health professional (e.g. registered nurse, nurse Provider, clinical social worker) within the 5 years should be included. If Molina determines there is a gap in work history exceeding six-months, the	The credentialing application or curriculum vitae must include at least 5-years of work history and must include the beginning and ending month and year for each position in the Provider's employment experience. If a Provider has had continuous employment for five years or more, then there is no gap and no need to provide the month and year; providing the year meets the intent. Molina documents review of work history by including an electronic signature or initials of the employee who reviewed	All Providers	One-hundred-eighty (180) Calendar Days	Initial Credentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
Provider must clarify the gap either verbally or in writing. Verbal communication must be appropriately documented in the credentialing file. If Molina determines there is a gap in work history that exceeds one-year, the Provider must clarify the gap in writing.	the work history and the date of review on the credentialing checklist or on any of the work history documentation.			
Malpractice History Provider must supply a history of malpractice and professional liability claims and settlement history in accordance with the application. Documentation of malpractice and professional liability claims and settlement history is requested from the Provider on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.	▪ National Provider Data Bank (NPDB) report	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
State Sanctions, Restrictions on licensure or limitations on scope of practice Provider must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations and non-renewals. Provider must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing, or failure to proceed with an application in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional	▪ Provider must answer the related questions on the credentialing application. ▪ If there are any yes answers to these questions, a detailed written response must be submitted by the Provider. ▪ The appropriate State/Federal agencies are queried directly for every Provider and if there are any sanctions, restrictions or limitations, complete documentation regarding the action will be requested. ▪ The NPDB is queried for every Provider.	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider. Molina will also verify all licenses, certifications and registrations in every State where the Provider has practiced. At the time of initial application, the Provider must not have any pending or open investigations from any State or governmental professional disciplinary body.[25]. This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.				
Medicare, Medicaid and other Sanctions Provider must not be currently sanctioned, excluded, expelled or suspended from any State or federally funded program including but not limited to the Medicare or Medicaid programs. Provider 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 Provider.	▪ The HHS Inspector General, Office of Inspector General (OIG) is queried for every Provider. ▪ Molina queries for State Medicaid sanctions/exclusions/terminations through each State's specific Program Integrity Unit (or equivalent). In certain circumstances where the State does not provide means to verify this information and Molina has no way to verify State Medicaid sanctions/exclusions/te	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

[25] If a Provider's application is denied solely because a Provider 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 Provider may reapply as soon as Provider 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 (1) year from the date of original denial.

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
Provider 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 Provider.	rminations. ▪ The System for Award Management (SAM) system is queried for every Provider. ▪ The NPDB is queried for every Provider.			
Professional Liability Insurance Provider must have and maintain professional malpractice liability insurance with limits that meet Molina criteria as stated below unless otherwise stated in addendum B. This coverage shall extend to Molina Members and the Providers activities on Molina's behalf. **The required limits are as follows:** **Physician (MD,DO) Nurse Provider, Certified Nurse Midwife, Oral Surgeon, Physician Assistant, Podiatrist =** $1,000,000/$3,000,000 **All non-physician Behavioral Health Providers, Naturopaths, Optometrists =** $1,000,000/$1,000,000 **Acupuncture, Chiropractor, Massage Therapy, Occupational Therapy, Physical Therapy,**	A copy of the insurance certificate showing: ▪ Name of commercial carrier or statutory authority ▪ The type of coverage is professional liability or medical malpractice insurance ▪ Dates of coverage (must be currently in effect) ▪ Amounts of coverage ▪ Either the specific Provider name or the name of the group in which the Provider works ▪ Certificate must be legible Current Provider application attesting to current insurance coverage. The application must include the following: ▪ Name of commercial carrier or statutory authority ▪ The type of coverage is professional liability or medical malpractice insurance	All Provider types	Must be in effect at the time of decision and verified within One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
Speech Language Pathology = $200,000/$600,000	▪ Dates of coverage (must be currently in effect) ▪ Amounts of coverage Providers maintaining coverage under a Federal tort or self-insured are not required to include amounts of coverage on their application for professional or medical malpractice insurance. A copy of the Federal tort or self-insured letter or an attestation from the Provider showing active coverage are acceptable. Confirmation directly from the insurance carrier verifying the following: ▪ Name of commercial carrier or statutory authority ▪ The type of coverage is professional liability or medical malpractice insurance ▪ Dates of coverage (must be currently in effect) ▪ Amounts of coverage			
Inability to Perform Provider must disclose any inability to perform essential functions of a Provider in their area of practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider. An inquiry regarding inability to perform essential functions may vary. Molina may accept more general or extensive language to query Providers	▪ Provider must answer all the related questions on the credentialing application. ▪ If there are any yes answers to these questions, a detailed written response must be submitted by the Provider. ▪ The attestation must be signed and dated within one-hundred-eighty (180) calendar days of credentialing decision	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
about impairments.				
Lack of Present Illegal Drug Use Provider must disclose if they are currently using any illegal drugs/substances. An inquiry regarding illegal drug use may vary. Providers may use language other than "drug" to attest they are not presently using illegal substances. Molina may accept more general or extensive language to query Providers about impairments; language does not have to refer exclusively to the present, or only to illegal substances. If a Provider discloses any issues with substance abuse (e.g. drugs, alcohol) the Provider must provide evidence of either actively and successfully participating in a substance abuse monitoring program or successfully completing a program.	▪ Provider must answer all the related questions on the credentialing application. ▪ If there are any yes answers to these questions, a detailed written response must be submitted by the Provider. ▪ If the Provider discloses they are currently participating in a substance abuse monitoring program, Molina will verify directly with the applicable substance abuse monitoring program to ensure the Provider is compliant in the program or has successfully completed the program. ▪ The attestation must be signed and dated within one-hundred-eighty (180) calendar days of credentialing decision	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
Criminal Convictions Provider must disclose if they have ever had any criminal convictions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider. Provider must not have been convicted of a felony or pled guilty to a felony for a healthcare related crime including but not limited to healthcare fraud, patient abuse and the unlawful manufacture distribution or dispensing of a controlled substance.	▪ Provider must answer the related questions on the credentialing application. If there are any yes answers to these questions, a detailed written response must be submitted by the Provider. ▪ If there are any yes answers to these questions, and the crime is related to healthcare, a national criminal history check will be run on the Provider. ▪ The attestation must be signed and dated within	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
	one-hundred-eighty (180) calendar days of credentialing decision			
Loss or Limitation of Clinical Privileges Provider must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Provider has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.	▪ Provider must answer the related questions on the credentialing application. If there are any yes answers to these questions, a detailed written response must be submitted by the Provider. ▪ The NPDB will be queried for all Providers. ▪ If the Provider has had disciplinary action related to clinical privileges in the last five (5) years, all hospitals where the Provider has ever had privileges will be queried for any information regarding the loss or limitation of their privileges.	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
Hospital Privileges Providers must list all current hospital privileges on their credentialing application. If the Provider has current privileges, they must be in good standing. Providers may choose not to have clinical hospital privileges if they do not manage care in the inpatient setting.	The Provider's hospital privileges are verified by their attestation on the credentialing application stating the Provider has current hospital admitting privileges.	Physicians and Podiatrists	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
Medicare Opt Out Providers 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.	CMS Medicare Opt Out is queried for every Provider. If a Provider opts out of Medicare, that Provider may not accept Federal reimbursement for a period of two (2) years and may not be contracted with Molina for any Medicare or Duals	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
	(Medicare/Medicaid) lines of business.			
NPI Provider must have a National Provider Identifier (NPI) issued by the Centers for Medicare and Medicaid Services (CMS).	▪ On-line directly with the National Plan & Provider Enumeration System (NPPES) database.	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
SSA Death Master File Providers must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File. If a Provider's Social Security number is listed on the SSA Death Master File database, Molina will send the Provider a conflicting information letter to confirm the Social Security number listed on the credentialing application was correct. If the Provider confirms the Social Security number listed on the SSA Death Master database is their number, the Provider will be administratively denied or terminated. Once the Provider's Social Security number has been removed from the SSA Death Master File database, the Provider can reapply for participation into the Molina network.	▪ On-line directly with the Social Security Administration Death Master File database.	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
Review of Performance Indicators Providers going through recredentialing must have documented review of performance indicators collected through clinical quality monitoring process, the utilization management system, the grievance system, enrollee satisfaction surveys,	Written documentation from the Molina Quality Department and other departments as applicable will be included in all recredentialing files.	All Providers	One-hundred-eighty (180) Calendar Days	Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
and other quality indicators.				
Denials Providers denied by the Molina Credentialing Committee are not eligible to reapply until one (1) year after the date of denial by the Credentialing Committee. At the time of reapplication, Provider must meet all criteria for participation.	▪ Confirmation from Molina's systems that the Provider has not been denied by the Molina Credentialing Committee in the past 1-year.	All Providers	One-hundred-eighty (180) Calendar Days	Initial Credentialing
Terminations Providers terminated by the Molina Credentialing Committee or terminated from the Molina network for cause are not eligible to reapply until five years after the date of termination. At the time of reapplication, Provider must meet all criteria for participation.	▪ Confirm from Molina's systems that the Provider has not been terminated by the Molina Credentialing Committee or terminated from the Molina network for cause in the past 5-years.	All Providers	One-hundred-eighty (180) Calendar Days	Initial Credentialing
Administrative denials and terminations Providers denied or terminated administratively as described throughout this policy are eligible to reapply for participation anytime as long as the Provider meets all criteria for participation.	▪ Confirmation from Molina's systems if a Provider was denied or terminated from the Molina network, that the reason was administrative as described in this policy.	All Providers	One-hundred-eighty (180) Calendar Days	Initial Credentialing
Employees of Providers denied, terminated, under investigation or in the Fair Hearing Process Molina may determine, in its sole discretion, that a Provider is not eligible to apply for network participation if the Provider is an employee of a Provider or an employee of a company owned in whole or in part by a Provider, who has been denied or terminated from network participation by Molina, who is currently in the Fair Hearing Process, or who is under investigation by Molina.	When a Provider is denied or terminated from network participation or who is under investigation by Molina, it will be verified if that Provider has any employees. That information will be reviewed by the Credentialing Committee and/or Medical Director and a determination will be made if they can continue participating in the network.	All Providers	Not applicable	Initial and Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
Molina also may determine, in its sole discretion that a Provider cannot continue network participation if the Provider is an employee of a Provider or an employee of a company owned in whole or in part by a Provider, who has been denied or terminated from network participation by Molina. For purposes of these criteria, a company is "owned" by a Provider when the Provider has at least five percent (5%) financial interest in the company, through shares or other means.				

Burden of Proof

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

Provider Termination and Reinstatement

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

If Molina is unable to recredential a Provider within thirty-six (36) months because the Provider is on active military assignment, maternity leave or sabbatical, but the contract between Molina and the Provider remains in place, Molina will recredential the Provider upon his or her return. Molina will document the reason for the delay in the Provider's file. At a minimum, Molina will verify that a Provider who returns has a valid license to practice before he or she can resume seeing Patients. Within sixty (60) calendar days of notice, when the Provider resumes practice, Molina will complete the recredentialing cycle. If either party terminates their contract and there was a break in service for more than thirty (30) calendar days, Molina will initially credential the Provider before the Provider rejoins the network.

Providers Terminating with a Delegate and Contracting with Molina Directly

Providers credentialed by a delegate who terminate their contract with the delegate and either have an existing contract with Molina or wish to contract with Molina directly must be credentialed by Molina within six (6) months of the Provider's termination with the delegate. If the Provider has a break in service more than thirty (30) calendar days, the Provider must be initially credentialed prior to reinstatement.

Credentialing Application

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

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

The Process for Making Credentialing Decisions

All Providers requesting participation with Molina must complete a credentialing application. To be eligible to submit an application, Providers must meet all the criteria outlined above in the section

titled “Criteria for Participation in the Molina Network”. Providers requesting initial credentialing may not provide care to Molina Members until the credentialing process is complete and final decision has been rendered.

Molina recredentials its Providers at least every thirty-six (36) months. Approximately six (6) months prior to the recredentialing due date, the Provider’s application will be downloaded from CAQH (or a similar NCQA© accepted online applications source), or a request will be sent to the Provider requesting completion of a recredentialing application.

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

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

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

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

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

Process for Delegating Credentialing and Recredentialing

Molina will delegate credentialing and recredentialing activities to Independent Practice Associations (IPA) and Provider Groups that meet Molina’s requirements for delegation. Molina’s Delegation Oversight Committee (DOC) must approve all delegation and sub delegation arrangements, and

retains the right to limit or revoke any and all delegated credentialing activities when a delegate fails to meet Molina's requirements.

Molina's Credentialing Committee retains the right to approve new Providers and Provider sites and terminate Providers, Providers and sites of care based on requirements in the Molina Credentialing Policy.
To be delegated for credentialing, IPAs and Provider Groups must:

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

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

Prevention
Molina takes appropriate steps to protect against discrimination occurring in the credentialing and recredentialing processes. Molina maintains a heterogeneous credentialing committee Membership. It is also required that each committee Member signs an affirmative statement annually to make decisions in a nondiscriminatory manner.

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

Notification of Credentialing Decisions

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

Confidentiality and Immunity

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

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

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

By providing patient care services at Molina, a Provider:

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

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

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

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

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

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

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

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

The Director in charge of Credentialing grants access to electronic credentials files only as necessary to complete credentialing work or as required by Law. Access to these documents are restricted to authorized staff, Credentialing Committee Members, peer reviewers and reporting bodies as authorized by the Credentialing Committee or the Governing Board of Molina. Each person is given a unique user ID and password. It is the strict policy of Molina that employees keep their passwords

confidential and never share their passwords with anyone. All Credentialing employees are prompted to change their passwords into the system every three (3) months.

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

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

Providers Rights during the Credentialing Process

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

The Provider must notify the Credentialing Department and request an appointed time to review their file and allow up to seven (7) calendar days to coordinate schedules. A Medical Director and the Director responsible for Credentialing or the Quality Improvement Director will be present. The Provider has the right to review all information in the credentials file except peer references or recommendations protected by Law from disclosure.

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

Providers Right to Correct Erroneous Information

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

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

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

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

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

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

Providers Right to be Informed of Application Status

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

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

Credentialing Committee

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

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

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

Committee Composition

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

- Behavioral Health
- Dental
- Family Medicine
- Internal Medicine
- Pediatrics
- OB/GYN
- Surgery

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

Committee Members Roles and Responsibilities

- Committee Members participate in and support the functions of the Credentialing Committee by attending meetings, providing input and feedback and overall guidance of the Credentialing Program.
- Review/approve credentialing program policy and related policies established by Molina on an annual basis, or more often as deemed necessary.
- Review and consider each applicant’s information based on criteria and compliance requirements. The Credentialing Committee votes to make final recommendations regarding applicant’s participation in the Molina network.

- Conduct ongoing monitoring of those Providers approved to be monitored on a "watch status."
- Access clinical peer input when discussing standards of care for a particular type of Provider when there is no committee member of that specialty.
- Ensure credentialing activities are conducted in accordance with Molina's Credentialing Program.
- Review quality improvement findings as part of the recredentialing and the ongoing monitoring process.

Excluded 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 Member/Provider is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. Where Molina 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

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

Medicare and Medicaid Sanctions and Exclusions

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

Molina also monitors each State Medicaid sanctions/exclusions/terminations through each State's specific Program Integrity Unit (or equivalent). Molina reviews each State's published report within thirty (30) days of its release to identify if any Molina Provider is found to be sanctioned/excluded/terminated from any State's Medicaid program. If a Molina Provider is found

to be sanctioned/excluded/terminated, the Provider will be immediately terminated in every State where they are contracted with Molina and for every line of business.

Sanctions or Limitations on Licensure

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

NPDB Continuous Query

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

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

Member Complaints/Grievances

Each Molina Health Plan has a process in place to investigate Provider-specific complaints from Members upon their receipt. Molina evaluates both the specific complaint and the Provider's history of issues, if applicable. The history of complaints is evaluated for all Providers at least every six (6) months.

Adverse Events

Each Molina Health Plan has a process in place for monitoring Provider adverse events at least every six (6) months. An adverse event is an injury that occurs while a Member is receiving health care services from a Provider. Molina monitors for adverse events at least every six (6) months.

Medicare Opt-Out

Providers participating in Medicare must not be listed on the Medicare Opt-Out report. Molina reviews the Opt-Out reports released from the appropriate Medicare financial intermediary showing all of the providers who have chosen to Opt-Out of Medicare. These reports are reviewed within thirty (30) calendar days of their release. If a Provider opts out of Medicare, that Provider may not

accept Federal reimbursement for a period of two (2) years. These Provider contracts will be immediately terminated for the Molina Medicare line of business.

Social Security Administration (SSA) Death Master File

Molina screens Provider names against the SSA Death Master File database during initial and recredentialing to ensure Provider are not fraudulently billing under a deceased person's social security number. The names are also screened on a monthly basis to ensure there are no matches on the SSA Death Master File between credentialing cycles. If Molina identifies an exact match, the Provider will be immediately terminated for all lines of business effective the deceased date listed on the SSA Death Master File database.

System for Award Management (SAM)

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

Program Integrity (Disclosure of Ownership/Controlling Interest)

Medicaid Managed Care health plans are required to collect specific information from network Providers prior to contracting and during credentialing to ensure that it complies with Federal regulations that require monitoring of Federal and State sanctions and exclusions databases. This monitoring ensures that any network Providers and the following details of any individual/entity being contracted and those individuals/entities affiliated with the contractor are appropriately screened against these sources, ensuring compliance with Social Security Act (SSA) section 1903(i)(2) of the Act; 42 CFR 455.104, 42 CFR 455.106, and 42 CFR 1001.1901(b). The categorical details required and collected are as follows:

a. Molina requires a current and complete Disclosure of Ownership and Control Interest Form during the credentialing process. Molina screens all individual names and entities listed on the form against the OIG, SAM, Medicare Opt-Out and each State's specific Program Integrity Unit databases at the time of initial credentialing and recredentialing. These individual names and entities are also screened monthly for any currently sanctioned/excluded/terminated individuals or entities. Molina will not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity This monitoring ensures that any individual/entity being contracted and those individuals/entities affiliated with the contractor are appropriately screened against Federal and State agency sources, ensuring compliance with 42 CFR §455. The following categorical details are collected and required on the Disclosure of Ownership and Control Interest during the credentialing and recredentialing process:

    i. Detailed identifying information for any individual who has ownership or controlling interest in the individual/entity being contracted if that individual has a history of criminal activity related to Medicaid, Medicare, or Title XX services (see 42 CFR §455.106).

ii. Detailed identifying information for all individuals who exercise operational or managerial control either directly or indirectly over daily operations and activities (see 42 CFR §455.101).

iii. Detailed identifying information for all individuals or entities that have a five percent (5%) or more ownership or controlling interest in the individual/entity being contracted (see 42 CFR §455.104).

b. Molina requires the Disclosure of Ownership and Control Interest Form be reviewed and re-attested to every thirty-six (36) months to ensure the information is correct and current.

c. Molina screens the entire contracted Provider network against the OIG, SAM, Medicare Opt-Out, each State's specific Program Integrity Unit and Social Security Death Master File databases at initial credentialing and recredentialing, as well as, monthly for any currently sanctioned/excluded/terminated individuals or entities. Molina will not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity.

d. Molina will immediately recover any payments for goods and services that benefit excluded individuals and entities that it discovers. Molina will immediately terminate any employment, contractual and control relationships with an excluded individual and entity that it discovers.

e. If a State specific Program Integrity Unit notifies Molina an individual or entity is excluded from participation in Medicaid, Molina will terminate all beneficial, employment, and contractual and control relationships with the excluded individual or entity immediately.

Office Site and Medical Record Keeping Practices Review

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

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

Range of Actions, Notification to Authorities and Provider Appeal Rights

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

Range of Actions Available

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

- Monitor on a Watch Status
- Require formal corrective action
- Denial of network participation
- Termination from network participation
- In cases where the Medical Director determines the circumstances pose an immediate risk to patients, a Provider may be summarily suspended from participation in the network, without prior notice, pending review and investigation of information relevant to the case.

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

Criteria for Denial or Termination Decisions by the Credentialing Committee

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

a. The Provider's professional license in any State has or has ever had any informal or formal disciplinary orders, decisions, agreements, disciplinary actions or other actions including but not limited to, restrictions, probations, limitations, conditions suspensions and revocations.
b. Provider has or has ever surrendered, voluntarily or involuntarily, his or her professional license in any State while under investigation by the State or due to findings by the State resulting from the Provider's acts, omissions or conduct.
c. Provider has any pending statement of charges, notice of proposed disciplinary actions, notice of agency action or the equivalent from any State or governmental professional disciplinary body which based on the judgment of the Credentialing Committee establishes an immediate potential risk to the quality of care or service delivered by the Provider to Molina Members.
d. Provider has or has ever had any restrictions, probations, limitations, conditions, suspensions or revocations on their Federal Drug Enforcement Agency (DEA) certificate or Registration.
e. Provider has a condition, restriction or limitation on their license, certification or registration related to an alcohol, chemical dependency, or health condition or if other evidence indicates that the Provider has an alcohol, chemical dependency problem or health condition and there is no clear evidence and documentation demonstrating that the Provider has complied with all such conditions, limitations, or restrictions and is receiving treatment adequate to ensure that

the alcohol, chemical dependency problem or health condition will not affect the quality of the Provider's practice.

f. Provider has or has ever had sanctions of any nature taken by any Governmental Program or professional body including but not limited to, Medicare, Medicaid, Federal Employee Program or any other State or Federal program or agency.
g. Provider has or has ever had any denials, limitations, suspensions or terminations of participation of privileges or surrendered privileges while under investigation by any health care institution, plan, facility or clinic.
h. Provider's history of medical malpractice claims or professional liability claims or settlements reflect what constitutes a pattern of questionable or inadequate treatment or contain what constitutes any gross or flagrant incident or incidents of malpractice.
i. Provider has a criminal history, including, but not limited to, any criminal charges, criminal investigations, convictions, no-contest pleas and guilty pleas.
j. Provider has or has ever had involvement in acts of dishonesty, fraud, deceit or misrepresentation that relate to or impact or could relate to or impact the Provider's professional conduct or the health, safety or welfare of Molina Members.
k. Provider has or has ever engaged in acts which Molina, in its sole discretion, deems inappropriate.
l. Provider has or has ever had a pattern of Member complaints or grievances in which there appears to be a concern regarding the quality of service provided to Molina Members.
m. Provider has not complied with Molina's quality assurance program.
n. Provider is found to have rendered a pattern of substandard care or is responsible for any gross or flagrant incident of substandard care.
o. Provider has or has ever displayed inappropriate patterns of referral, which deviate substantially from reasonably expected patterns of referral.
p. Provider makes or has ever made any material misstatements in or omissions from their credentialing application and attachments.
q. Provider has ever rendered services outside the scope of their license.
r. Provider has or has ever had a physical or mental health condition that may impair their ability to practice with the full scope of licensure and qualifications, or might pose a risk of harm on patients.
s. Provider has or has ever failed to comply with the Molina Medical Record Review Guidelines.
t. Provider has or has ever failed to comply with the Molina Site Review or Medical Record Keeping Practice Review Guidelines.

Monitoring Providers Approved on a 'Watch Status' by the Committee

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

When a Provider is approved on watch status, the Credentialing Department conducts the follow-up according to the Credentialing Committee direction. Any unusual findings are reported immediately

to the Molina Medical Director to determine if immediate action is necessary. Every unusual finding is reviewed in detail at the next Credentialing Committee meeting for review and recommendation.

Corrective Action

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

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

- Identifying the performance issues that do not meet expectations
- What actions/processes will be implemented for correction
- Who is responsible for the corrective action
- What improvement/resolution is expected
- How improvements will be assessed
- Scheduled follow-up, monitoring (compliance review, normally not to exceed six (6) months)

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

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

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

Summary Suspension

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

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

- A description of the action being taken.
- Effective date of the action.

- The reason(s) for the action and/or information being investigated.
- Information (if any) required from the Provider.
- The length of the suspension.
- The estimated timeline for determining whether or not to reinstate or terminate the Provider.
- Details regarding the Providers right to request a fair hearing within thirty (30) calendar days of receipt of the notice and their right to be represented by an attorney or another person of their choice (see Fair Hearing Plan policy).
- If the Provider does not request a fair hearing within the thirty (30) calendar days, they have waived their rights to a hearing.
- The action will be reported to the NPDB if the suspension is in place longer than thirty (30) calendar days.

Upon initiation of the suspension, the Medical Director and credentialing staff will commence investigation of the issues. Findings of the investigation will be presented to the Credentialing Committee.

The Credentialing Committee has the authority to implement corrective action, place conditions on the Provider's continued participation, discontinue the suspension or terminate the Provider.

Denial

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

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

Termination

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

Terminations for Reasons Other Than Unprofessional Conduct or Quality of Care

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

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

Terminations Based on Unprofessional Conduct or Quality of Care

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

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

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

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

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

Reporting to Appropriate Authorities

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

- Revocation, termination of, or expulsion from Molina Provider status.
- Summary Suspension in effect or imposed for more than thirty (30) calendar days.

- Any other final action by Molina that by its nature is reportable to the State Licensing Board and the NPDB.

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

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

A letter is then written to the appropriate State licensing boards describing the adverse action taken, the Provider it was taken against and a copy of the NPDB report is attached to the letter. This letter is sent certified to the appropriate State licensing boards within twenty-four (24) hours of receiving the final NPDB report. A copy of this letter is filed into the Provider's credentials file. The action is also reported to other applicable State entities as required.

Fair Hearing Plan Policy

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

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

1. Definitions
    a. Adverse Action shall mean an action that entitles a Provider to a hearing, as set forth in Section B (l)-(3) below.
    b. Chief Medical Officer shall mean the Chief Medical Officer for the respective Molina Affiliate State plan wherein the Provider is contracted.
    c. Days shall mean calendar days. In computing any period of time prescribed or allowed by this Policy, the day of the act or event from which the designated period of time begins shall not be included.
    d. Medical Director shall mean the Medical Director for the respective Molina Affiliate State plan wherein the Provider is contracted.
    e. Molina Plan shall mean the respective Molina Affiliate State plan wherein the Provider is contracted.
    f. Notice shall mean written notification sent by certified mail, return receipt requested, or personal delivery.
    g. Peer Review Committee or Credentialing Committee shall mean a Molina Plan committee or the designee of such a committee.
    h. Plan President shall mean the Plan President for the respective Molina Affiliate State plan wherein the Provider is contracted.

i. Provider shall mean physicians, dentists, and other health care Practitioners as defined by 42 USC 11151 and Social Security Act § 1861(u).
j. State shall mean the licensing board in the State in which the Provider practices.
k. State Licensing Board shall mean the State agency responsible for the licensure of Provider.
l. Unprofessional Conduct refers to a basis for corrective action or termination involving an aspect of a Provider's competence or professional conduct which is reasonably likely to be detrimental to patient safety or the delivery of quality care. Unprofessional conduct does not refer to instances where a Provider violates a material term of the Provider's contract with a Molina Plan.

2. Grounds for a Hearing

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

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

3. Notice of Action

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

a. State the reasons for the action;
b. State any Credentialing Policy provisions that have been violated;
c. Advise the Provider that he/she has the right to request a hearing on the proposed Adverse Action;
d. Advise the Provider that any request for hearing must be made in writing within thirty (30) days following receipt of the Notice of Action, and must be sent to the respective Molina Plan Medical Director by certified mail, return receipt requested, or personal delivery;
e. Advise the Provider that he/she has the right to be represented by an attorney or another person of their choice.
f. Advise the Provider that the request for a hearing ***must*** be accompanied by a check in the amount of $1,000.00 as a deposit for the administrative expenses of the hearing and specify that this amount will be refunded if the Adverse Action is overturned;

g. State that the proposed action or recommendation, if adopted, must be reported pursuant to State and Federal Law; and,
h. Provide a summary of the Provider's hearing rights or attach a copy of this Policy.

4. Request for a Hearing – Waiver

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

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

5. Appointment of a Hearing Committee

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

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

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

c. Responsibilities
The Hearing Committee shall:

i. Evaluate evidence and testimony presented.
ii. Issue a decision accepting, rejecting, or modifying the decision of the Peer Review Committee and/or Credentialing Committee.
iii. Maintain the privacy of the hearing unless the Law provides to the contrary.

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

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

6. Hearing Officer

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

b. Scope of Authority
The Hearing Officer shall have the sole discretion and authority to:

i. Exclude any witness, other than a party or other essential person.
ii. Determine the attendance of any person other than the parties and their counsel and representatives.
iii. For good cause shown to postpone any hearing upon the request of a party or upon a Hearing Committee's own initiative, and shall also grant such postponement when all of the parties agree thereto.

c. Responsibilities
The Hearing Officer shall:

i. Guide the hearing process, including endeavoring to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner;
ii. Ensure that proper decorum is maintained;
iii. Be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing;
iv. Issue rulings pertaining to matters of Law, procedure and the admissibility of evidence;
v. Issue rulings on any objections or evidentiary matters;
vi. Discretion to limit the amount of time;
vii. Assure that each witness is sworn in by the court reporter;
viii. May ask questions of the witnesses (but must remain neutral/impartial);
ix. May meet in private with the panel members to discuss the conduct of the hearing;
x. Remind all witnesses at the conclusion of their testimony of the confidentiality of the hearing;
xi. Participate in the deliberations of the Hearing Committee as a legal advisor, but shall not be entitled to vote; and,
xii. Prepare the written report.

7. Time and Place of Hearing

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

8. Notice of Hearing

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

a. The date, time and location of the hearing.
b. The name of the Hearing Officer.
c. The names of the Hearing Committee Members.
d. A concise statement of the affected Provider's alleged acts or omissions giving rise to the Adverse Action or recommendation, and any other reasons or subject matter forming the basis for the Adverse Action or recommendation which is the subject of the hearing.
e. The names of witnesses, so far as they are then reasonably known or anticipated, who are expected to testify on behalf of the Peer Review Committee and/or Credentialing Committee, provided the list may be updated as necessary and appropriate, but not later than ten (10) days prior to the commencement of the hearing.
f. A list of all documentary evidence forming the bases of the charges reasonably necessary to enable the Provider to prepare a defense, including all documentary

evidence which was considered by the Peer Review Committee and/or Credentialing Committee in recommending the Adverse Action.

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

9. Pre-Hearing Procedures

a. The Provider shall have the following pre-hearing rights:
   i. To inspect and copy, at the Provider's expense, documents upon which the charges are based which the Peer Review Committee and/or Credentialing Committee have in its possession or under its control; and
   ii. To receive, at least thirty (30) days prior to the hearing, a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the Provider to prepare a defense, including all evidence that was considered by the Peer Review Committee and/or Credentialing Committee in recommending Adverse Action.

b. The Hearing Committee shall have the following pre-hearing right:
   To inspect and copy, at Molina's expense, any documents or other evidence relevant to the charges which the Provider has in his or her possession or control as soon as practicable after receiving the hearing request.

c. The Hearing Officer shall consider and rule upon any request for access to information and may impose any safeguards required to protect the peer review process, privileges and ensure justice. In so doing, the Hearing Officer shall consider:
   i. Whether the information sought may be introduced to support or defend the charges;
   ii. The exculpatory or inculpatory nature of the information sought, if any;
   iii. The burden attendant upon the party in possession of the information sought if access is granted; and,
   iv. Any previous requests for access to information submitted or resisted by the parties.

d. The Provider shall be entitled to a reasonable opportunity to question and object to or challenge the impartiality of members of the Hearing Committee and the Hearing Officer. Challenges to the impartiality of any Hearing Committee member or the Hearing Officer shall be ruled on by the Hearing Officer.

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

f. Failure to disclose the identity of a witness or produce copies of all documents expected to be produced at least ten (10) days before the commencement of the hearing

shall constitute good cause for a continuance or limitation of the evidence or the testimony if deemed appropriate by the Hearing Officer.

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

h. Conduct of Hearing

i. Rights of the Parties

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

i. Call and examine witnesses for relevant testimony.
ii. Introduce relevant exhibits or other documents.
iii. Cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues.
iv. Otherwise rebut evidence.
v. Have a record made of the proceedings.
vi. Submit a written statement at the close of the hearing.
vii. Receive the written recommendation of the Hearing Officer or Hearing Committee, including a statement of the basis for the recommendations, upon completion of the hearing.

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

k. Course of the Hearing

i. Each party may make an oral opening statement.
ii. The Peer Review Committee and/or Credentialing Committee shall call any witnesses and present relevant documentary evidence to support its recommendation.
iii. The affected Provider may then call any witnesses and present relevant documentary evidence supporting his/her defense.
iv. The Hearing Committee or Officer has the discretion to vary the course of the hearing, but shall afford a full and equal opportunity to all parties for the presentation of material and relevant evidence and for the calling of witnesses.
v. The Hearing Committee shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence shall not be necessary. All evidence shall be taken in the presence of the entire Hearing Committee and all of the parties, except when agreed to by the parties, or determined by the Hearing Officer.

l. Use of Exhibits

i. Exhibits, when offered by either party, may be received into evidence by the Hearing Committee as ruled upon by the Hearing Officer.
ii. A description of the exhibits in the order received shall be made a part of the record.

m. Witnesses

i. Witnesses for each party shall submit to questions or other examination.
ii. The Hearing Officer shall have the power to sequester witnesses (exclude any witness, other than a party or other essential person, during the testimony of any

other witness). The names and addresses of all witnesses and a description of their testimony in the order received shall be made a part of the record.

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

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

n. Rules for Hearing:

i. Attendance at Hearings

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

ii. Communication with Hearing Committee

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

iii. Interpreter

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

10. Close of the Hearing

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

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

a. A summary of facts and circumstances giving rise to the hearing.

b. A description of the hearing, including:

i. The panel members' names and specialties;

ii. The Hearing officer's name;

iii. The date of the hearing;

iv. The charges at issue; and,

v. An overview of witnesses heard and evidence.

c. The findings and recommendations of the Hearing Committee.

d. Any dissenting opinions desired to be expressed by the hearing panel members.

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

11. Burden of Proof

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

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

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

12. Provider Failure to Appear or Proceed

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

13. Record of the Hearing/Oath

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

14. Representation

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

15. Postponements

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

16. Notification of Finding

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

17. Final Decision

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

18. Reporting

In the event the Chief Medical Officer/Plan President adopts the proposed decision of the Peer Review Committee and/or Credentialing Committee taking or recommending the Adverse Action, Molina will submit a report to the State Licensing Board and the NPDB, as required. Reports shall be made in accordance with the Credentialing Program Policy.

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

19. Exhaustion of Internal Remedies

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

20. Confidentiality and Immunity

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

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

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

By providing patient care services at Molina, a Provider:

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

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

a. Any type of application or reapplication received by the Provider;
d. Actions reducing, suspending, terminating or revoking a Provider's status, including requests for corrective actions, investigation reports and documents and all other information related to such action;
e. Hearing and appellate review;
f. Peer review and utilization and quality management activities;
g. Risk management activities and Claims review;
h. Potential or actual liability exposure issues;
i. Incident and/or investigative reports;
j. Claims review;
k. Minutes of all meetings by any committees otherwise appropriately appointed by the Board;
l. Any activities related to monitoring the quality, appropriateness or safety of health care services;
m. Minutes of any Committees and Subcommittees related to monitoring the quality, appropriateness or safety of health care services;
n. Any Molina operations and actions relating to Provider conduct.

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

Immunity from Liability for Providing Information: No representative or third parties shall be liable to a Provider for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative or to any third party pursuant to

authorization by the Provider, or if permitted or required by Law, or these Policies and Procedures, provided that such representative or third parties acts in good faith and without malice.

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

Section 14. Delegation

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

Delegation of Administrative Functions

Administrative services which may be delegated to IPAs, Medical Groups, Vendors, or other organizations include:

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

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

Note: The Molina Member's ID card will identify which group the Member is assigned. If Claims Administration and/or UM has been delegated to the group, the ID card will show the delegated group's remit to address and phone number for referrals and prior authorizations.

Delegation Criteria

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

Call Center

To be delegated for Call Center functions, Vendors must:

- Have a Vendor contract with Molina (Molina does not delegate call center functions to IPAs or Provider Groups).

- Have a Call Center delegation pre-assessment completed by Molina to determine compliance with all applicable State and Federal regulatory requirements.
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30) days.
- Correct deficiencies within the timeframes identified in the corrective action plan (CAP) when issues of non-compliance are identified by Molina.
- Protect the confidentiality of all PHI as required by Law.
- Have processes in place to identify and investigate potential Fraud, Waste and Abuse.
- Must have an automated call system that allows the Vendor to confirm Member benefits and eligibility during the call.
- Agree to Molina's contract terms and conditions for Call Center delegates.
- Submit timely and complete Call Center delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Current call center is able to demonstrate compliance with service level performance, average speed to answer, abandonment rate, and/or percentage of calls that are complaints meet CMS and/or state requirements, depending on the line(s) of business delegated.

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

Care Management

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

- Be certified by the National Committee for Quality Assurance (NCQA) for complex case management and disease management programs.
- Have a current complex case management and disease management program descriptions in place.
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30) days.
- Pass a care management pre assessment audit, based on NCQA and State requirements, and Molina business needs.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina.
- Agree to Molina's contract terms and conditions for care management delegates.
- Submit timely and complete Care Management delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Comply with all applicable federal and state Laws.

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

A Medical Group, IPA, or Vendor may request Care Management delegation from Molina through Molina's Delegation Oversight Manager or through the Medical Group, IPA, or Vendor's Contract Manager. Molina will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate Care Management responsibilities is based on the Medical Group, IPA, or Vendor's ability to meet Molina, State and Federal requirements for delegation.

Claims Administration

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

- Have a capitation contract with Molina and be in compliance with the financial reserves requirements of the contract.
- Be delegated for UM by Molina.
- Protect the confidentiality of all PHI as required by Law.
- Have processes in place to identify and investigate potential Fraud, Waste, and Abuse.
- Have a Claims Administration delegation pre-assessment completed by Molina to determine compliance with all applicable State and Federal regulatory requirements for Claims Administration.
- Correct deficiencies within timeframes identified in the corrective action plan (CAP) when issues of non-compliance are identified by Molina.
- Must have an automated system capable of accepting electronic claims in an ICD 10 compliant format.
- Must have an automated system capable of providing Molina with the Encounter Data required by the state in a format readable by Molina.
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30) days.
- Agree to Molina's contract terms and conditions for Claims Delegates.
- Submit timely and complete Claims Administration delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Within forty-five (45) days of the end of the month in which care was rendered, provide Molina with the Encounter Data required by the state in a format compliant with HIPAA requirements.
- Provide additional information as necessary to load Encounter Data within (30) days of Molina's request.
- Comply with the standard Transactions and Code Sets requirements for accepting and sending electronic health care Claims information and remittance advice statements using the formats required by HIPAA.
- Comply with all applicable Federal and State Laws.

- When using Molina's contract terms to pay for services rendered by Providers not contracted with IPA or group, follow Molina's Claims Administration policies and guidelines, such as the retroactive authorization policy and guidelines for Claims adjustments and review of denied Claims.

A Medical Group, IPA, or Vendor may request Claims Administration delegation from Molina through Molina's Delegation Oversight Manager or through the Medical Group, IPA, or Vendor's Contract Manager. Molina will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate Claims Administration responsibilities is based on the Medical Group, IPA, or Vendor's ability to meet Molina, State and Federal requirements for delegation.

Credentialing

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

- Pass Molina's credentialing pre-assessment, which is based on NCQA credentialing standards.
- 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, SAM, and all published state Medicaid exclusion lists a minimum of every thirty days.
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30) days.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina.
- 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 to the applicable Molina contact.
- Comply with all 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.

Note: If the Medical Group, IPA, or Vendor is an NCQA Certified or Accredited organization, a modified pre-assessment audit may be conducted. Modification to the audit depend 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 Medical Group, IPA, or Vendor sub-delegates Credentialing functions, the sub-delegate must be NCQA accredited or certified in Credentialing functions, or demonstrate and ability to meet all Health Plan, NCQA, and State and Federal requirements identified

above. 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.

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

Non-Emergent Medical Transportation (NEMT)

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

- Have a Vendor contract with Molina (Molina does not delegate NEMT functions to IPAs or Medical Groups).
- Pass Molina's NEMT pre-assessment, which is based on State and Federal NEMT requirements.
- Have automated systems that allow for scheduling of NEMT appointments, confirmation of Member eligibility, and availability of NEMT benefits.
- Have processes in place to ensure protection of Member PHI.
- Have processes in place to identify and investigate potential Fraud, Waste, and Abuse.
- Have a network of vehicles and drivers that meet State and Federal safety requirements.
- Ensure on at least an annual basis that vehicles continue to meet State and Federal vehicle safety requirements.
- Ensure that drivers continually meet State and Federal safety requirements.
- Have a process in place for reporting of all accidents, regardless of harm to Member, to Molina within forty-eight (48) hours.
- Agree to Molina's contract terms and conditions for NEMT delegates, including applicable Call Center and/or Claims Administration delegation requirements.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina.
- Submit timely and complete NEMT delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Comply with all applicable Federal and State Laws.

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

requirements, Health Plan, State and Federal requirements, and a process to implement corrective action if issues of non-compliance are identified.

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

Utilization Management (UM)

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

- Have a UM program that has been operational at least one year prior to delegation, and includes an annual UM Program evaluation and annual Inter Rater Reliability audits of all levels of UM staff.
- Pass Molina's UM pre-assessment, which is based on NCQA, State and Federal UM standards, and Molina Policies and Procedures.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina.
- Ensure that only licensed physicians/dentists medical necessity denial decisions.
- Ensure that only appropriate levels of clinical staff make medical necessity approval decisions.
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30) days.
- Agree to Molina's contract terms and conditions for UM delegates.
- Submit timely and complete UM delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Comply with the standard Transactions and Code Sets requirements for authorization requests and responses using the formats required by HIPAA.
- Comply with all applicable federal and state Laws.

Note: If the Medical Group, IPA, or Vendor is an NCQA Certified or Accredited organization, a modified pre-assessment audit may be conducted. Modifications to the audit depend 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.

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

A Medical Group, IPA, or Vendor may request UM delegation from Molina through Molina's Delegation Oversight Manager or through the Medical Group, IPA, or Vendor's Contract Manager. Molina will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate UM

responsibilities is based on the Medical Group, IPA, or Vendor's ability to meet Molina, State and Federal requirements for delegation.

Quality Improvement/Preventive Health Activities

Molina does not delegate Quality Improvement activities to Provider organizations. Molina will include all network Providers, including those in Medical Groups, IPAs, or Vendors who are delegated for other functions (Claims, Credentialing, UM, etc.) in its Quality Improvement Program activities and preventive health activities. Molina encourages all contracted Provider organizations to conduct activities to improve the quality of care and service provided by their organization. Molina would appreciate receiving copies of studies conducted or data analyzed as part of the Medical Group, IPA, or Vendor's Quality Improvement Program.

Delegation Reporting Requirements

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

Section 15 – Fraud, Waste and Abuse

Introduction

Molina Healthcare is dedicated to the 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 the education of appropriate employees, vendors, Providers, and associates doing business with Molina Healthcare of New Mexico.

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Mission Statement

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

A. Regulatory Requirements

Federal False Claims Act

The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. 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

On February 8, 2006, the Deficit Reduction Act ("DRA") was signed into law, which became effective on January 1, 2007. The DRA aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

Health care entities like Molina Healthcare who receive or pay out at least $5 million dollars in Medicaid funds per year must comply with the DRA. As a contractor doing business with Molina Healthcare, 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 a whistleblower.

The Federal False Claims Act and the Medicaid False Claims Act have Qui Tam language commonly referred to as "whistleblower" provisions. 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 acts. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

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

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

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

Definitions

Fraud:

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

Waste:

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

Abuse:

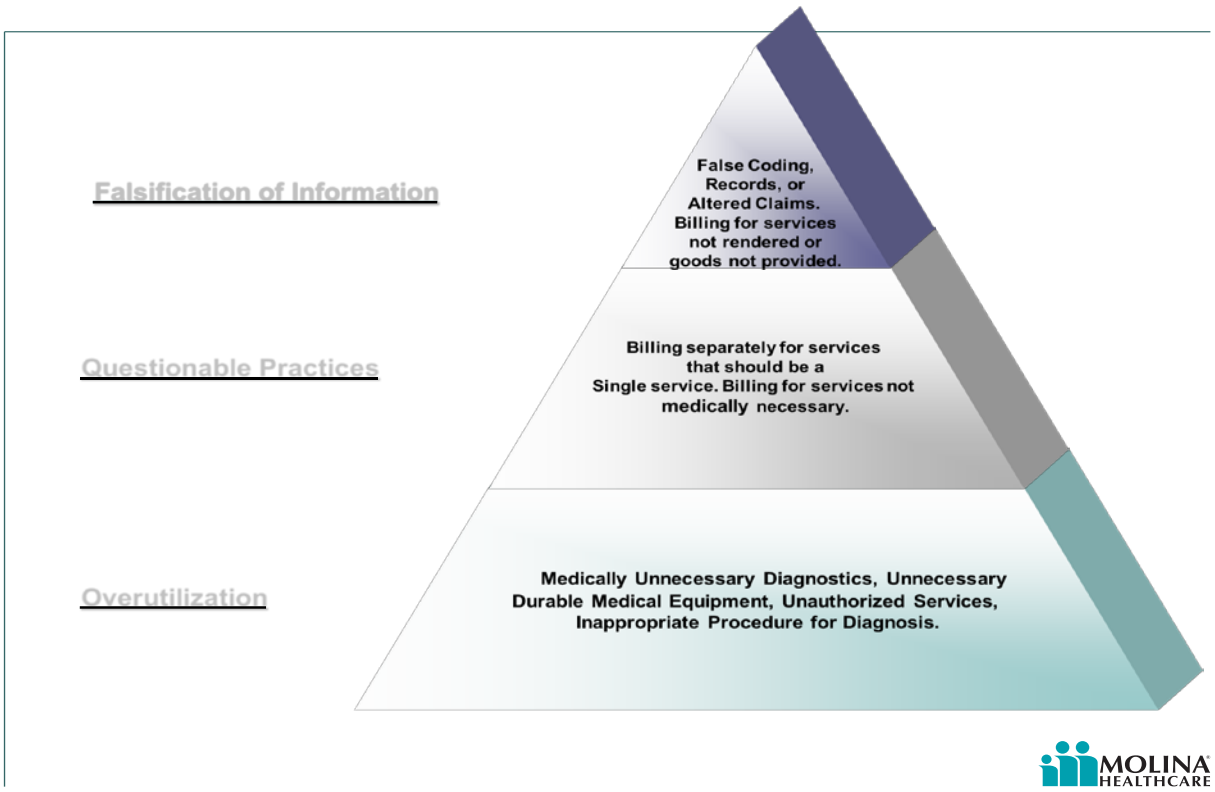
Actions that may, directly or indirectly, result in: unnecessary costs to the Medicaid Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

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 physician knowingly and willfully referring Medicaid patients to health care facilities in which or with which the physician has a financial relationship. (The Stark Law)
- Altering claims forms and/or medical record documentation in order to get a higher level of reimbursement.
- Balance billing a Medicaid 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.
- Up-coding, which is when a Provider does not bill the correct code for the service rendered, and instead uses a code for a like services that costs more.
- Using the adjustment payment process to generate fraudulent payments.



Examples of Fraud, Waste, and Abuse by a Member

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

- Benefit sharing with persons not entitled to the Member's benefits.
- Conspiracy to defraud government funded programs like Medicare or Medicaid.
- Doctor shopping, which occurs when a Member consults a number of Providers for the purpose of inappropriately obtaining services.
- Falsifying documentation in order to get services approved.
- Forgery related to health care.
- Prescription diversion, which occurs when a Member obtains a prescription from a Provider for a condition that he/she does not suffer from and the Member sells the medication to someone else.

Review of Provider Claims and Claims System

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

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

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

Prepayment Fraud, Waste, and Abuse Detection Activities

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

Post-payment Recovery Activities

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

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

If a Molina Healthcare auditor is denied access to Provider's records, all of the claims for which Provider received payment from Molina Healthcare is immediately due and owing. If Provider

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

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

Review of Provider

The Credentialing Department is responsible for monitoring practitioners through the various government reports, including:

- Federal and State Medicaid sanction reports.
- Federal and state lists of excluded individuals and entities.
- List of parties excluded from Federal Procurement and Non-procurement Programs.
- Medicaid suspended and ineligible provider list.
- Monthly review of state Medical Board sanctions list.
- Review of license reports from the appropriate specialty board.

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

Provider/Practitioner Education

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

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

The Credentialing staff will also present the list of physicians found on the Medicaid sanctions report to the Compliance Committee for review and potential oversight of action.

Provider Profiling

Molina Healthcare performs claims audits to detect potential external health care fraud, waste, or abuse. These audits of provider billings are based on objective and documented criteria. Molina Healthcare uses a fraud, waste, and abuse detection software application designed to score and profile provider and member billing behavior and patterns. The software utilizes a fraud finder engine to identify various billing behaviors, billing patterns, known schemes, as well as unknown patterns by taking into consideration a provider or member's prior billing history. The software statistically identifies what is expected based on prior history and specialty norms, including recognition of pattern changes from those identified in profiled historical paid claims data and ongoing daily claims batches. If a score reaches a certain parameter or threshold, the provider or member is placed on a list for further review.

Molina Healthcare will inform the provider of the billing irregularities and request an explanation of the billing practices. The Compliance department, with the aid of the Special Investigation Unit, may conduct further investigation and take action as needed.

Cooperating with Special Investigation Unit Activities

Molina Healthcare's Special Investigation Unit may conduct prepayment, concurrent, or post-payment review. Providers will cooperate with Special Investigation Unit activities, and will provide requested documentation at no charge to the unit following the timelines indicated in such requests. Failure to cooperate may result in further action, up to and including termination of the Provider contract.

Reporting Fraud, Waste and Abuse

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina Healthcare AlertLine. AlertLine is an external telephone and web based reporting system hosted by NAVEX Global, a leading provider of compliance and ethics hotline services. AlertLine telephone and web based reporting is available 24 hours a day, 7 days a week, 365 days a year. When you make a report, you can choose to remain confidential or anonymous.

If you choose to call AlertLine, a trained professional at NAVEX Global will note your concerns and provide them to the Molina Healthcare Compliance Department for follow-up. If you elect

to use the web-based reporting process, you will be asked a series of questions concluding with the submission of your report. Reports to AlertLine can be made from anywhere within the United States with telephone or internet access. Molina Healthcare AlertLine can be reached toll free at 1-866-606-3889 or you may use the service's website to make a report at any time at **https://molinahealthcare.alertline.com**

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

Molina Healthcare of New Mexico, Inc.
Attn: Compliance
400 Tijeras Ave NW, Suite 200
Albuquerque, NM 87102

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, Medicaid ID number and any other identifying information.

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

Medical Assistance Division	New Mexico Human Services Department
Quality Assurance Bureau **P.O. Box 2348** **Santa Fe, NM 87504-2348** **NMMedicaidFraud@state.nm.us** **Local in Santa Fe: (505) 827-3100** **Toll free: (888) 997-2583**	**Office of Inspector General** **Local in Albuquerque: (505) 827-8141** **Toll free: (800) 338-4082** **HSDOIGFraud@state.nm.us**

Medicaid Fraud Control Unit
111 Lomas NW, Suite 300
Albuquerque, NM 87102
Local in Albuquerque: (505) 222-9000 or Toll free: (800) 678-1508

Section 15 – Preventive Health Guidelines and Clinical Practice Guidelines

Preventive Health Guidelines

Molina Healthcare's guidelines are derived predominately from the latest recommendations of the *United States Preventive Services Task Force*; *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* published by the National Center for Education in Maternal and Child Health, American Academy of Pediatrics; Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices, and other professional organizations. Although there is a wide array of preventive services, we have chosen to identify age specific preventive interventions and have prioritized them based on the effectiveness of interventions that improve outcomes. These guidelines are meant to be a standard level of care and do not preclude the delivery of additional preventive services depending on the individual needs of the patient.

Providers may contact Molina Healthcare Health Improvement Program for a complete set of our Preventive Health Guidelines for Children, Adolescents, Adults and Pregnancy or see the Molina Healthcare web link to obtain them.
http://www.molinahealthcare.com/medicaid/providers/nm/resource/pages/guide_prevent.aspx

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

The EPSDT Program is a federally mandated program ensuring comprehensive health care to Medicaid recipients from birth to twenty-one (21) years of age. EPSDT visits include:

- Comprehensive health and development history;
- Comprehensive unclothed physical exam including height, weight and BMI percentile;
- Appropriate immunizations according to the most current Advisory Committee on Immunization Practices (ACIP) Schedule*
- Laboratory tests including Hematocrit/Hemoglobin at nine (9) months and thirteen (13) years;
- Blood Lead Screening at twelve (12) and twenty-four (24) months;
- Nutrition screening;
- Development/Behavioral Assessment;
- Health education and Anticipatory Guidance;
- Dental Screening; and
- Vision and Hearing Screening.

If any component of the above EPSDT screen is not completed, this must be noted in the medical record including whether the EPSDT or Well Child Check was offered and declined, or the patient/guardian chose not to complete the screen.

Practitioners who have implemented a formal system for delivering preventive services increase his/her delivery in the clinical setting. There is also scientific evidence to support the effectiveness of using certain tools in a system to deliver preventive services - such as preventive care flow sheet, reminder notes on patient charts, and patient reminders. Molina Healthcare currently mails out educational reminders through its monthly Patient Appointment Reminder Card for children and adults.

Tot-to-Teen Health Checks

The initial screening component of the EPSDT Program is called the Tot-to-Teen Health Check. The Primary Care Practitioner (PCP) initiates all follow-up and referral services at the Tot-to-Teen Health Check.

Claims Processing

Submit the Centers for Medicare & Medicaid Services (CMS)-1500 (08/05) form with the encounter code from the following codes. For reference, the following resources are available to assist with coding for EPSDT visits including ICD-10 codes:

Bright Futures Preventive Medicine Coding Fact Sheet
https://www.aap.org/en-us/Documents/coding_factsheet_brightfuturespreventivemedicine.pdf

Medicaid.gov Keeping America Healthy: EPSDT
https://www.medicaid.gov/medicaid/benefits/epsdt/index.html

Envision New Mexico EPSDT Resource Handbook
http://envisionnm.org/xpdf/EPSDT_Resource_Handbook.pdf

Immunizations Codes

Vaccine Specific Current Procedural Terminology (CPT) Code with corresponding Administration Code.

Practitioners must document all immunizations administered in the New Mexico Statewide Immunization Information System (NMSIIS). For assistance, please contact Provider Services. All practitioners that enter immunizations into NMSIIS will receive an incentive of five dollars when billing CPT-4 code 99080 in conjunction with the immunization codes.

Blood Lead Screen Code

CPT-4 code: 83655

Practitioners are encouraged to follow the New Mexico Department of Health protocols for Childhood Blood Lead Screening. Molina Healthcare provides these protocols to practitioners in the EPSDT Provider Toolkit.

Vision Screening at Twelve (12) and Twenty-four (24) Months
CPT-4 code: 99173

Hearing Screening
CPT-4 code: 92551 – 92553, 92555 – 92556, 92587 (in conjunction with well child exam)
Developmental screening: Thirty (30) months
CPT-4 code: 96110

EPSDT Periodicity Schedule

The basic schedule for Tot-to-Teen Health Checks is as follows (see this Section for full description of each of the following office visits):

Infancy	**Early Childhood**
By one month	12 months
At two months	15 months
4 months	18 months
6 months	24 months
30 months (developmental screen)	3 years
9 months	

Middle Childhood	**Adolescence**
4 to 11 years	12 to 20 years

Appointment Scheduling Assistance
EPSDT patients may receive assistance with appointment scheduling by contacting Molina Healthcare's Member Services Department directly in **Albuquerque at (505) 341-7493 or toll free (855) 322-4078.**

Transportation
EPSDT also provides assistance with transportation to and from appointments under certain circumstances. Patients may contact Transportation **toll free at (888) 593-2052.**

EPSDT Provider Tools
Molina Healthcare has Provider Engagement Team (PET) tools and resources available that contains information to assist your practice in understanding the importance of EPSDT and to encourage proper documentation of preventive services provided to your patients. For your copy of EPSDT Provider tools, call the Health Improvement Hotline in **Albuquerque at (505) 342-4660 extension 182618 or toll free at (800) 377-9594 extension 182618.**

For more information about documentation of preventive health services provided to children and adolescents, contact the Health Improvement Hotline in **Albuquerque at (505) 342-4660 extension 182618 or toll free at (800) 377-9594 extension 182618.**

Preventive Health Standards

As a part of continuous quality improvement, Molina Healthcare encourages practitioners to routinely document preventive health screenings including laboratory tests and immunizations. Practitioners are required to document all immunizations given to Members in the New Mexico Statewide Immunization Information System (NMSIIS). Molina Healthcare will consider the following when evaluating services provided:

- Were immunizations for adults offered as appropriate? (Flu, Pneumococcal, Tetanus & Varicella) Or is there a note that immunizations were offered and patient refused to consent and/or refused access to care?
- Has the patient had a Mammography in the last one to two years? (Females aged 40-69 years) Or is there a note that mammography was offered and patient refused to consent and/or refused access to care?
- Has the patient (females twenty-one [21]-sixty-five [65] years) had a Papanicolaou (PAP) in the last three (3) years? If the patient is at high risk, is there an annual PAP? If a PAP is not done, is there a note that the screen was offered and the patient refused to consent and/or refused access to care?
- Has the patient had a colorectal cancer screen by fecal occult blood in the last year, or colonoscopy or sigmoidoscopy or double contrast barium periodicity to be determined by the practitioner (Adults $\geq$ fifty [50] years old)? If screen not done, is there a note that the screen was offered and the patient refused to consent and/or refused access to care?
- Has the patient (over age eighteen [18]) received a blood pressure measurement at least every two (2) years? If screen not done, is there a note that the screen was offered and the patient refused to consent and/or refused to access care?
- Are all sexually active women age twenty-five (25) or younger screened for Chlamydia?
- Are all female Members over age twenty-five (25) who are considered at high risk (inconsistently use barrier contraception, have more than one (1) sex partner, or have had a sexually transmitted disease in the past) screened for Chlamydia? If the test not done is there a note that the screen was offered and the patient refused to consent and/or refused to access care?

Preventive Health Specific to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Visits Up to the Age of Twenty- One (21)

- Is there a comprehensive health and developmental history, including assessment of physical and mental health development?
- Is there a comprehensive unclothed physical exam?
- Are there appropriate immunizations to age and history unless contraindicated? If immunizations are not done, is there a note that they were offered and refused (included refusal to access care), or is there documentation that copies of immunizations were requested and not brought in?

- Laboratory tests, including an appropriate lead blood level assessment at age one (1) and prior to two (2) years old.
- Is health education including anticipatory guidance documented?
- Are vision and hearing test orders and results documented?
- If not done, is there a note that the EPSDT or Well Child Check was offered and declined, or the patient/guardian chose not to access?

Preventive Health Standards for Pregnancy

- Is the patient screened for preeclampsia in accordance with the most current American College of Obstetricians and Gynecologists (ACOG) recommendations? If not done, is there a note that the screen was offered and the patient refused to consent and/or refused to access care?
- Is the patient screened for Rh incompatibility in accordance with the most current ACOG recommendations? If Rh test was not done, is there a note that the screen was offered and the patient refused to consent and/or refused to access care?
- Is the patient's fetus screened for Down's syndrome and neural tube defects in accordance with the most current ACOG recommendations-Maternal Serum Alpha-Fetoprotein (MSAFP)? If test not done, is there a note that the screen was offered and refused (including refused to access care) or a note of "too late" as pregnancy is beyond twenty (20) weeks?
- Is the patient screened for hemoglobinopathies in accordance with the most current ACOG recommendations Hematocrit (H & H)? If H & H not done is there a note that the screen was offered and the patient refused and/or refused to access care?
- Is the patient screened for vaginal and rectal group B streptococcal infection in accordance with the most current ACOG recommendations? If screen not done, is there a note that the screen was offered and the patient refused and/or refused to access care?
- Is the patient screened and counseled for Human Immunodeficiency Virus (HIV) in accordance with the most current ACOG recommendations? If screening and counseling not done, is there a note that the screen was offered and the patient refused to consent and/or refused to access care?

For more information about documentation of preventive health services provided to children, adolescents, and adults contact the Health Improvement Hotline in **Albuquerque at (505) 342-4660 extension 182618 or toll free at (855) 322-4078.**

Clinical Practice Guidelines

Clinical Practice Guidelines are available for review and printing on the Molina Healthcare website at www.molinahealthcare.com in the Clinical Practice Guideline section. If you do not have internet capability, a hard copy of any Clinical Practice Guideline can be mailed to you. Contact Provider Services in Albuquerque (505) 342-4660 or toll free (800) 377-9594.

Clinical Practice Guidelines are available for the following conditions:

- Acute Otitis Media
- Asthma
- Asthma Action Plan for NM Schools
- Bronchitis
- COPD
- Diabetes
- Heart Failure
- Hypertension
- Low Back Pain
- Obesity
- Upper Respiratory Infection

Section 17 – Privacy Practices and Health Insurance Portability and Accountability Act (HIPAA)

HIPAA Requirements and Information

HIPAA (The Health Insurance Portability and Accountability Act)

Molina Healthcare's Commitment to Patient Privacy

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

Provider Responsibilities

Molina Healthcare expects that its contracted Provider will respect the privacy of Molina Healthcare Members (including Molina Healthcare 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 Healthcare provides its Members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how Molina Healthcare uses and discloses their PHI and includes a summary of how Molina Healthcare safeguards their PHI.

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

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

Applicable Laws

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

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

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[26]. 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, inpatient review, and retrospective review of "services[27]."

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

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

Confidentiality of Alcohol and Substance Abuse Patient Records

Federal Alcohol or Substance Abuse Confidentiality Regulations apply to any entity or individual providing federally assisted alcohol or drug abuse prevention functions. Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with alcohol or drug abuse treatment or programs are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects substance abuse information, the federal alcohol and substance abuse regulations are more restrictive than HIPAA and they do not allow disclosure without the Member's written consent except in very limited circumstances

Inadvertent Disclosures of PHI

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

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

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

or securely destroy the PHI of the affected Molina Healthcare Members in order to protect their privacy. The Provider agrees to not further use or disclose such PHI, unless otherwise permitted by Law.

Written Authorizations

Uses and disclosures of PHI that are not permitted or required under applicable Law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable State Law. A sample Authorization for the Use and Disclosure of Protected Health Information is included at the end of this section.

Patient Rights

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

1. Notice of Privacy Practices

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

2. Requests for Restrictions on Uses and Disclosures of PHI

Patients may request that a 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 Healthcare Member and patient PHI. As more

Providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate cyber security measures. Providers should recognize that identity theft – both financial and medical -- is a rapidly growing problem and that their patients trust their health care Providers to keep their most sensitive information private and confidential.

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

HIPAA Transactions and Code Sets

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

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

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

1. Click on the area titled "I'm a Health Care Professional"
2. Click the tab titled "HIPAA"
3. And then click on the tab titled "HIPAA Transaction Readiness" or "HIPAA Code Sets"

Code Sets

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

National Provider Identifier

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

Additional Requirements for Delegated Providers

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

Reimbursement for Copies of PHI

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

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

Member Authorization to Release Protected Health Information
English Form: Member Authorization to Release PHI
Spanish Form: Member Authorization to Release PHI

Section 18 – Claims and Reimbursement

Prior to contracting with Molina Healthcare, providers must be enrolled with New Mexico Medicaid. All providers with a National Provider Identifier (NPI) that is not associated with an active New Mexico Medicaid Fee-For-Service or Managed Care Provider record (status 60 or 70) in the Omnicaid system and has or will provide health care services are required to enroll with the New Mexico Medical Assistance Division (MAD) Medicaid Program or their claims will be denied.

Claims Submissions

Participating providers are required to submit claims to Molina with appropriate documentation and within ninety (90) days from the date of service when Molina Healthcare is the Member's primary insurance. All claims must be submitted within one (1) year from the date of service when Molina Healthcare is the secondary carrier when the primary carrier's filing limit is one (1) year, and within ninety (90) days of the other carrier's Explanation of Benefit (EOB).

Providers must utilize electronic billing though a clearinghouse or Molina's Provider Portal, and use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims) and use electronic Payer ID number 09824.

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.

- Claims that do not comply with Molina's electronic Claim submission requirements will be denied.
- 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.
- Inaccurate, incomplete, or untimely submissions and re-submissions may result in denial of the claim; and any paper claim submissions will be denied.

Required Elements - The following information must be included on every claim:

- Member name, date of birth and Molina Member ID number.
- Member's gender.
- Member's address.
- Date(s) of service.
- Valid International Classification of Diseases diagnosis and procedure codes.
- Valid revenue, CPT or HCPCS for services or items provided.
- Valid Diagnosis Pointers.
- Total billed charges for service provided.
- Place and type of service code.
- Days or units as applicable.
- Provider tax identification.

- National Provider Identifier (NPI). A valid NPI is required on all claims submissions. Providers must report any changes in their NPI or subparts to Molina as soon as possible, not to exceed thirty (30) calendar days from the change.
- Rendering Provider as applicable.
- Provider name and billing address.
- Place of service and type (for facilities).
- Disclosure of any other health benefit plans.
- E-signature.
- Service Facility Location.

Claim Submission Forms

Molina Healthcare requires that all professional claims are submitted on a CMS-1500 Form, and all technical/facility claims are submitted on a UB-04 Form with the National Provider Identifier (NPI). Please refer to Section H for additional information regarding NPI. Both of these forms are available via the links below:

- **CMS 1500 Form**
- **UB 04 Form**

Revenue Codes

Practitioners/providers are required to use industry standard billing forms and coding. Claims submitted on a UB-04 form should include the appropriate type of bill, specific revenue codes and HCPCS or other codes as appropriate for services.

Skilled nursing facility (SNF), sub-acute care, or psychiatric services should be billed with the appropriate specific revenue codes and should not be billed using general medical surgical revenue codes.

Corrected Claims Submissions

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

EDI (Clearinghouse) Submission:

837P

- In the 2300 Loop, the CLM segment (claim information) CLM05-3 (claim frequency type code) must indicate one of the following qualifier codes:
  - "7"–REPLACEMENT (replacement of prior claim)
  - "8"-VOID (void/cancel of prior claim)

- In the 2300 Loop, the REF segment (claim information) must include the original claim number of the claim being corrected, found on the remittance advice.

837I

- Bill type for UB claims are billed in loop 2300/CLM05-1. In Bill Type for UB, the 7 or 8 goes in the third digit for "frequency".
- In the 2300 Loop, the REF segment (claim information) must include the original claim number of the claim being corrected, found on the remittance advice.

Encounter Data

Each capitated Provider/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 reporting to HFS, rate setting and risk adjustment, hospital rate setting, the Quality Improvement program and HEDIS® reporting.

Encounter data must be submitted once per month, and must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I – Institutional, 837P – Professional, and 837D -- Dental. Data must be submitted with Claims level detail for all non-institutional services provided. For institutional services, only those services covered by Molina should be reported.
Molina shall have a comprehensive automated and integrated Encounter data system capable of meeting these requirements.

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

When your Encounters are filed electronically you should receive:

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

Molina Healthcare is required by the New Mexico Human Services Department to report all services rendered to MHNM Members. The reporting of these services, also known as encounter data reporting is a critical contractual requirement. Molina Healthcare works closely with its providers and subcontractors to ensure they are in compliance with Encounter Data submission requirements. This includes training, technical assistance and other activities to support providers and subcontractors to ensure compliance with the HIPAA 837 format. Molina Healthcare also partners with the clearinghouse Change Healthcare to identify opportunities to assist practitioners/providers to use electronic claims submission and improve the quality of claims and encounter data submitted.

Electronic Claims Submission / EDI

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

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

Molina Healthcare offers the following electronic Claims submission options:

- Submit Claims directly to Molina Healthcare of New Mexico via the Provider Portal
- Submit Claims to Molina via your regular EDI clearinghouse using Payer ID 09824.

Provider Portal:
Molina's Provider Portal offers a number of claims processing functionalities and benefits:

- Available to all Providers at no cost
- Available 24 hours per day, 7 days per week
- Ability to add attachments to claims
- Easily and quickly void claims
- Check claims status
- Receive timely notification of a change in status for a particular claim

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

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

When your Claims are filed via a Clearinghouse:

- You should receive a 999 acknowledgement from your clearinghouse.
- You should also receive 227CA response file with initial status of the claims from your clearinghouse.
- You should contact your local clearinghouse representative if you experience any problems with your transmission.

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

Paper Claim Submissions

Paper claim submissions are not encouraged by Molina Healthcare. Claims submitted via paper typically take longer to adjudicate. Electronic submission is strongly suggested.

Clean Claim Criteria

The following items **must** be included to be considered a "clean" claim:

- Member's name;
- Member's correct date of birth;
- Provider's National Provider Identifier (NPI);
- Complete diagnosis code carried out to the highest degree (4th or 5th digit);
- Valid date of service;
- Valid Current Procedural Terminology (CPT-4) code or Health Care Procedure Coding System (HCPCS) code;*
- Valid Revenue (REV) codes; and
- Valid modifiers (if appropriate);

Telehealth providers:* ***For professional service (distance site), use the usual service code (covered under telehealth) and add a GT modifier as appropriate (example: 90801 GT) to indicate service was provided via telehealth. Only one service code is specific to telehealth. Q3014 facility fee (originating site) compensates providers who support telehealth patient sites. Two (2) separate claims need to be submitted when billing for both distance and originating sites.*

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

Providers should maintain current coverage information on all Members.

Medicaid is the payer of last resort. Private and governmental carriers must be billed prior to billing Molina Healthcare or medical groups/IPAs. Provider shall make reasonable inquiry of Members to learn whether Member has health insurance, benefits or Covered Services other than from Molina Healthcare or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Molina Healthcare of said entitlement. In the event that coordination of benefits occurs, Provider shall be compensated based on the state regulatory COB methodology. Primary carrier payment information is required with the claim submission. Provider can submit claims with attachments, including EOBs and other required documents, by utilizing Molina's Provider Portal.

Third Party Liability (TPL)

Molina Healthcare is the payer of last resort and will make every effort to determine the appropriate Third Party payer for services rendered. Molina Healthcare may deny Claims when Third Party has been established and will process Claims for Covered Services when probable TPL has not been established or third party benefits are not available to pay a Claim. Molina Healthcare will attempt to

recover any third-party resources available to Members and shall maintain records pertaining to TPL collections on behalf of Members for audit and review.

Order of Benefit Determination

COB is a method of determining who has primary responsibility when there is more than one insurance coverage available to pay benefits. The combined payments provided by the primary and secondary plans cannot be more than the total of charges. When benefits are coordinated by Medicaid (payer of last resort), the total payment will not exceed the Medicaid eligible payment.

Molina Healthcare follows the "Order of Benefit Determination Rules" to identify the primary insurance carrier. These rules are explained below:

- The program that covers the patient as an employee is primary;
- If an individual is a covered Member by more than one (1) group program as an active employee and as a retired employee, the program covering the individual as an active employee is primary. this rule also applies to dependents of the Member;
- If an individual is enrolled in a group retiree program and also as a dependent on an active working spouse's coverage, the dependent's active coverage is primary;
- **Molina Healthcare will be the payer of last resort.** Centennial Care claims will represent the balance of the eligible amount minus the payment from the primary insurance company. The combined payments will not exceed what would normally have been paid by Molina Healthcare in the absence of other coverage. If the payment from the primary insurance company is equal to or greater than the Medicaid Fee Schedule or contractual amount, no payment will be made by Molina Healthcare. The provider is **not** permitted to bill the Centennial Care Member for the balance.
- When two (2) plans cover the same child as a dependent (parents NOT separated or divorced), and neither plan is a Medicaid program:
  - The plan of the parent whose birthday falls earlier in the year is primary over the plan of the parent whose birthday falls later in the calendar year; but
  - If both parents have the same birthday, the plan that covered one (1) parent longer is primary over the plan that covered the other parent for a shorter time; or
  - If the other coverage plan does not use the birthday rule described above, but instead uses a rule based on the gender of the parent, the rule of the other plan will determine the order of benefits.
- When two plans cover the same child as a dependent (parents are separated or divorced), the primary payer is determined in this order:
  - First , the plan of the parent who has custody of the child;
  - Second, the plan of the spouse of the parent who has custody of the child;
  - Third, the plan of the natural parent not having custody of the child; or
  - If the specific terms of a court decree require one parent to be responsible for the dependent's health care expenses, that parent's plan will be primary over any other plan covering the child as a dependent. This applies as long as the plan designated as primary has actual knowledge of those terms.
- If none of the above rules establishes an order of benefits, the plan that covered the person longer is primary over the plan that covered the person for a shorter time; and
- If it is determined that a Centennial Care Member has Medicare, their coverage will

coordinate with the appropriate Centennial Care Plan. All claims should be submitted to Medicare or Medicare Managed Care Plan as the primary carrier, then to the appropriate Centennial Plan for secondary payment.

Submitting COB/TPL Claims

When submitting claims for Members for which Molina Healthcare is not the primary insurance, you must attach a copy of the primary payer's EOB with the exception of home services billed by Early, Periodic Screening and Diagnostic Treatment (EPSDT) Providers for waiver children, prenatal and pregnancy care. Molina Healthcare will bill the primary insurance directly for these services unless the rendering practitioner/provider has already done so, and has provided the primary payer's EOB. The primary payer's EOB must match the submitted claim, and include descriptions of all associated remit messages so that Molina Healthcare may appropriately consider the charges.

Timely Filing Suggestions

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 any and all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by Provider to Molina within ninety (90) days after the following have occurred: discharge for inpatient services or the Date of Service for outpatient services; and Provider has been furnished with the correct name and address of the Member's health maintenance organization.

Except as otherwise provided by Law or provided by Government Program requirements, any Claims that are not submitted to Molina within these timelines below will not be eligible for payment and Provider hereby waives any right to payment therefore.

Acceptable Proof of Timely Filing - Acceptable proof of timely filing includes, but is not limited to any one item or combination of:

- EOB issued by Molina Healthcare;
- Provider statements/ledgers indicating the original submission date as well as all follow-up attempts;
- Dated copy of Molina Healthcare correspondence referencing the claim (correspondence must be specific to the referenced claim);
- Other carrier's EOB when Molina Healthcare is the secondary payer (one [1] year from the date of service);
- Other carrier's EOB when submitted to the wrong carrier (ninety [90] days); and
- Documentation of inquiries (calls or correspondence) made to Molina Healthcare for follow-up that can be verified by Molina Healthcare.

Key to EOB Messages

Explanation of benefits (EOB) is defined on the EOB document sent with claims (i.e. payments, adjustments, denials, etc.). Please call Member Services if additional information is needed. The EOB is a single document with pages clearly and consecutively numbered. The EOB includes:

- The check, if applicable, is printed on the lower third of the first page;
- All settled claims within the Remittance Advice (RA) run cycle appear in alphabetical order first by rendering provider, then by patient last name, first name, and middle initial. If there are multiple claims for the same patient, they are presented in the order they were processed;
- Reason codes are conveniently displayed at the charge line or summarized at the end of the remittance advice or directly below the explanation of payment for the specified claim; and
- Each claim has a heading, which includes the provider internal patient account number (control number).

Reimbursement Guidance and Payment Guidelines

Providers are responsible for submission of accurate claims. Molina Healthcare requires coding of both diagnoses and procedures for all claims. The required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM for diagnoses. For procedures, the Healthcare Common Procedure Coding System Level 1 (CPT codes), Level 2 and 3 (HCPCS codes) are required for professional and outpatient claims. Inpatient hospital claims require ICD-10-PCS (International Classification of Diseases, 10th Revision, Procedure Coding System). Furthermore, 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 Healthcare utilizes a claims adjudication system that encompasses edits and audits that follow Federal requirements and also administers payment rules based on generally accepted principles of correct coding. Payment rules based on generally accepted principles of correct coding include, but are not limited to, the following:

- Manuals and RVU files published by the Centers for Medicare and Medicaid Services (CMS), including:
  - National Correct Coding Initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and Medically Unlikely Edits (MUEs). If a professional organization has a more stringent/restrictive standard than a Federal MUE, the professional organization standard may be used.
  - Medicare National Coverage Determinations (NCDs).
  - Medicare Local Coverage Determinations (LCDs).
  - CMS Physician Fee Schedule Relative Value File (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.
- 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 Federal guidelines.

- Molina Healthcare policies based on the appropriateness of health care and medical necessity.
- Payment policies published by Molina Healthcare.

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

Provider acknowledges Molina Healthcare's right to conduct post-payment billing audits. Provider shall cooperate with Molina Healthcare's audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical records, Provider's charging policies, and other related data. Molina Healthcare shall use established industry Claims adjudication and/or clinical practices, State, and Federal guidelines, and/or Molina Healthcare's policies and data to determine the appropriateness of the billing, coding, and payment.

Claim Resubmission/Adjustments

ALL requests must include sufficient documentation to support the request. The Provider Reconsideration Review Request Form (PRR) can be accessed on the Molina Healthcare website at this link: **PRR Form**

All claims resubmission or adjustment requests must be submitted and received by Molina Healthcare within:

- Ninety (90) days of dated correspondence from Molina Healthcare referencing the claim (correspondence must be specific to the referenced claim);
- One (1) year from the date of service when Molina Healthcare is the secondary payer when the primary carrier's filing limit is one (1) year, and ninety (90) days of the other carrier's EOB; and
- Ninety (90) days of the other carrier's EOB when submitted to the wrong payer.

Claim Editing Process

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

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

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

Claim Review

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

Claim Auditing

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

Members Held Financially Harmless

- Providers contracted with Molina cannot bill the Member for any covered benefits. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.
- Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina to the Provider
- Provider agrees to accept payment from Molina as payment in full, or bill the appropriate responsible party

The practitioner/provider will not seek to collect, accept payment from, or bill Molina Healthcare Members any amounts except applicable co-payments or coinsurance for the provision of covered services over and above those paid for by Molina Healthcare.

Practitioners/providers who participate in Medicaid agree to accept the amount paid as payment in full (see 42 C RF 447.15) with the exception of co-payment amounts required in certain Medicaid categories (Native Americans are exempt from co-payment requirements). Aside from co-payments, a provider may not bill a Member for any unpaid portion of the bill or for a claim that is not paid with the following exceptions:

- 1) The Member has been advised by the provider that the service is not a covered benefit; 2) The Member has been advised by the provider that he/she is not contracted with Molina Healthcare; and/or 3) The Member agrees in writing to have the service provided with full knowledge that he/she is financially responsible for payment.

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. 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 enrolled 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 www.molinahealthcare.com or by contacting our Provider Services Department.

Interest:

Molina Healthcare will pay interest each month on the amount of a clean claim (based upon the current Medicaid fee schedule) and not paid within thirty (30) calendar days of the date of receipt of an electronic claim. Interest will accrue from the 31st calendar day.

Overpayments

If, as a result of retroactive review of coverage decisions or payment levels, 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. Molina will not reduce payment to that Provider for other services unless the Provider agrees to the reduction or fails to respond to Molina's Claim as required in this subsection.

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.

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.

If, as a result of retroactive review of coverage decisions or payment levels, 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. Molina will not reduce payment to that Provider for other services unless the Provider agrees to the reduction or fails to respond to Molina's Claim as required in this subsection.

A Provider will 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.

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.

Practitioners/providers are required to report overpayments to Molina Healthcare by the later of the date which is sixty (60) calendar days after the date on which the overpayment was identified or the date any corresponding cost report is due, if applicable. A person has identified an overpayment if the person has actual knowledge of the existence of an overpayment or acts in reckless disregard or with deliberate indifference of the overpayment.

Self-Reporting

Within sixty (60) calendar days from the date on which the practitioner/provider identifies an overpayment, the practitioner / provider must send an "Overpayment Report" to the CONTRACTOR and HSD, which must include:

a. Provider's name;
b. Provider's tax identification number and National Provider Number;
c. How the overpayment was discovered;
d. The reason for the overpayment;
e. The health insurance claim number, as appropriate;
f. Date(s) of service;
g. Medicaid claim control number, as appropriate;
h. Description of a corrective action plan to ensure the Overpayment does not occur again;
i. Whether the Provider has a corporate integrity agreement (CIA) with the United States Health and Human Services Department Office of Inspector General (OIG) or is under the OIG Self-Disclosure Protocol;
j. The specific dates (or time-span) within which the problem existed that cause the overpayments;
k. If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment; and
l. The refund amount.

Refunds

All self-reported refunds for overpayments must be made by the provider to Molina Healthcare as an intermediary and are the property of Molina Healthcare unless HSD, the Recovery Audit Contractor or Medical Fraud and Elder Abuse Division (of the New Mexico Attorney General's Office) independently notified the Provider that an overpayment existed or Molina Healthcare fails to initiate recovery within twelve (12) months from the date the CONTRACTOR first paid the claim; or fails to complete the recovery within fifteen (15) months from the date the it first paid the claim. In cases where HSD, the RAC, or MFEAD identifies the overpayment, HSD will seek recovery of the Overpayment in accordance with NMAC §8.351.2.13.

The provider may:

a. request that Molina Healthcare permit installment payments of the Refund, such request

be agreed to by Molina Healthcare and the Provider; or

b. in cases where HSD, the RAC, or MFEAD identify the Overpayment, HSD will seek recovery of the Overpayment in accordance with NMAC §8.351.2.13.

Failure to Self-Report and/or Refund Overpayments

Overpayments that have been identified by the Provider and not self-reported within the sixty (60)-day timeframe are presumed to be false claims and are subject to referrals as Credible Allegations of Fraud.

Health Care Acquired Conditions (HCAC) and Never Events

Molina Healthcare has an established and systematic process to identify, investigate and review any Quality of Care, Adverse Event/Never Event, and/or service issues affecting Member care. This process includes researching the issue, resolution of the issue, and tracking facilities and providers for trend issues. Confirmed Adverse Events/Never Events are reported to Molina Healthcare's Professional Review Committee for recommendations and/or case closure. If it is determined that a HAC has occurred, payment will be denied. In such instances, please note that the provider is not allowed to bill the Member.

Barred from Participation

Molina Healthcare will not make payment to any practitioner/provider who has been barred from participation based on existing Medicare, Medicaid or State Children's Health Insurance Program sanctions, except for Emergency Services.

Reimbursement for Members Who Disenroll While Hospitalized

If a Member is hospitalized at the time of enrollment or disenrollment from an MCO or upon an approved switch to another Centennial Care MCO, the originating MCO is responsible for payment of all covered inpatient facility and professional services provided within a licensed acute care facility, or a non-psychiatric specialty unit or hospitals until the date of discharge. Upon discharge, the Member becomes the financial responsibility of the MCO receiving the capitation payment for that Member.

If a Member is hospitalized and is disenrolled from an MCO due to a loss in Medicaid coverage, the MCO is only financially liable for the inpatient hospitalization and associated professional services until such time that the Member is determined to be ineligible for Medicaid.

If a Member is in a Nursing Facility at the time of disenrollment (not including loss of Medicaid eligibility), Molina Healthcare be responsible for the payment of all Covered Services until the date of discharge or the date of disenrollment, whichever occurs first.

Section 19 – Member Advocacy - Grievance, Appeal and Fair Hearing Process

This section describes the process to be utilized by practitioners/providers **who are assisting** Members with complaints and appeals, as well as for providers who are themselves filing a complaint or appeal on their own behalf. The processes for Members will be discussed first.

- A **complaint (also known as a grievance)** is any dissatisfaction voiced by any Member on any aspect of his/her health care or health benefits plan *other* than a request for services;
- An **appeal** is a request for review of a denied specific health care service or non-payment for a health care service;

- Complaints and appeals are reviewed and resolved to promote Member satisfaction and in compliance with applicable state and federal law, regulations and guidelines. Complaints are processed in a confidential manner. Molina Healthcare employees are required to sign a confidentiality statement at the time of hire; and
- No person will be subject to retaliatory action by Molina Healthcare for any reason related to complaints or appeals.

Assisting Molina Healthcare Members When They Have a Complaint or Appeal

When practitioners/providers are trying to help a patient get a service covered, or have a complaint or appeal addressed, Molina Healthcare Member complaint or appeal processes apply. The Member may select someone of his/her choosing, including an attorney (at the Member's expense), to represent his/her complaint or appeal. If someone other than the Member files a complaint on the Member's behalf, an authorization to represent the Member must be submitted to Molina Healthcare. ***If you are filing the complaint or appeal on behalf of a Member, you must submit a signed authorization form from the Member before Molina Healthcare can accept the complaint or appeal request. This authorization form can be found by following this link:*** Provider Forms

If you receive a complaint or an issue from a Molina Member, please ask the Member to contact the Molina Member Services Department. If a Member is unable to call Molina for any reason, we ask that you take the basic information about the complaint or appeal from the Member. The information to file a written complaint or appeal on the Member's behalf may be sent via mail or fax to the attention of the Appeals Department at the address or fax number listed in this section.

The Member, the legal guardian of the Member, in the case of minors or incapacitated adults, the Member's provider, or the representative of the Member with the Member's written consent, has the right to file a written or oral complaint or appeal to Molina Healthcare or to the Human Services Department (HSD) Hearings Bureau on behalf of the Member. This information is also provided to Members in the Member Handbook. As previously discussed, if you are filing the complaint or appeal on behalf of the Member, you must submit a signed authorization form from the Member before Molina Healthcare can accept the complaint or appeal request.

Filing a Formal Verbal or Written Complaint or Appeal for Members

Molina Healthcare's Appeals Department for Members is also known internally as the Member Advocacy Department. The Member or representative of the Member (with the Member's written consent) has the right to file a formal verbal or written complaint or appeal if they are dissatisfied with some aspect of Molina Healthcare (i.e., provider, or health care received or requested and not received).

A Member or their representative may file an appeal of a Molina Healthcare Adverse Benefit

Determination within sixty (60) calendar days of receiving Molina Healthcare's notice of Adverse Benefit Determination, i.e. denial. Oral inquiries from Members seeking to appeal an Adverse Benefit Determination are treated as Appeals in order to establish the earliest filing date for the Appeal. Molina Healthcare accepts, investigates and provides a written resolution to all oral appeal requests. An oral appeal must be followed by a written appeal that is signed by the Member within thirteen (13) calendar days. Failure to file the written appeal within thirteen (13) calendar days will constitute withdrawal of the appeal. Molina Healthcare will make its best efforts to assist the Member as needed with the written appeal.

A network provider also has the right to file a formal verbal or written appeal with Molina Healthcare, on the Member's behalf with the Member's written consent, if he/she is dissatisfied with Molina Healthcare's decision to terminate, suspend, reduce, or not provide services to a Member.

To submit a formal verbal or written complaint or appeal on behalf of a Molina Healthcare Member, call or write to:

Molina Healthcare of New Mexico, Inc.
Attention: Appeals Department
P.O. Box 3887
Albuquerque, NM 87190-9859

Phone: Albuquerque (505) 342-4681 or Toll free (800) 580-2811
Fax: (505) 342-0583

Basic information needed when initiating a formal verbal or written complaint or appeal on behalf of a Member are:

- Member name;
- The Member's Molina Healthcare identification number;
- Telephone number (where Member can be reached during the day); and
- A brief description of the issue(s).

All formal verbal or written complaints and appeals are to be reported to Molina Healthcare which relies on the assistance of providers in facilitating the notification process as well as helping to resolve the Member's issues as quickly as possible. If a provider or someone other than the Member files a formal verbal or written complaint or appeal on any Member's behalf, an authorization to represent that Member must be submitted to Molina Healthcare.

When practitioners/providers assist a Molina Healthcare Member in trying to get a service covered, or a formal verbal or written complaint or appeal addressed, Molina Healthcare Member complaints and appeal processes apply. At any level of the formal verbal or written complaint and appeal process, the Member can select someone of his/her own choosing to represent him/her. This includes the legal guardian of the Member in the case of a minor or incapacitated adult, providers working on behalf of the Member with the Member's written permission,

and/or an attorney (at the Member's expense) to represent him/her.

Please contact Molina Healthcare if any Member needs the complaint and appeal information in a language other than English. Translation Services and Teletype/ Telecommunication Device for the Deaf (TTY/TDD) services for the hearing impaired are also available.

Accessing TTY/TDD Services

Our Complaint and Appeal Line is accessible to all Members. Deaf, hard of hearing, or speech-disabled Members can communicate with Molina Healthcare through the Relay New Mexico (Relay NM) Network. This service is available twenty-four (24) hours a day, seven (7) days a week. Members may access Relay NM by following these directions:

- Using your TTY text telephone, call the Relay NM operator **toll free at (800) 659-8331**;
- Type your message to the Relay NM operator, informing him/her that you would like to contact the Molina Healthcare Member Services Department in **Albuquerque at (505) 341- 7493 or toll free at (855) 322-4078;**
- The Relay NM operator voices the typed conversation to the Molina Healthcare Member Service Representative answering the call;
- The Member Service Representative can converse with the Member through the Relay NM operator, who then types the verbal communication to the Member; or
- Molina Healthcare Appeals Staff can also contact Members using the TTY text telephone by calling Relay NM **toll free at (800) 659-1779**, and asking the Relay NM Operator to call the Member and type the conversation to the Member.

Conversations are kept confidential by Molina Healthcare and Relay NM. Relay NM does not maintain records of actual conversations.

Expedited Review Processes

Internal/external expedited reviews on pre-service denials will be completed for all Members in accordance with the medical urgency of the case and will not exceed seventy-two (72) hours whenever:

- The life or health of a covered person may be jeopardized; and
- The covered person's ability to attain, maintain or regain maximum function may be jeopardized.

Such determination is based on:

- A request from the Member;
- A practitioner/provider's support of the Member's request;
- A practitioner/provider's request on behalf of the Member; or
- Molina Healthcare's independent determination.

If the expedited review request is denied, the Member and the practitioner/provider are notified

and the review is placed in the standard review timeframe (30 calendar days to resolve).

Automatic Expedited Appeals – ***In accordance with Medical Assistance Division Policy****, if a Member is inpatient and coverage for additional days is denied based on medical necessity, and if the conditions are met for an expedited appeal, Molina will automatically initiate an expedited appeal on behalf of the Member.*

Processing Member Formal Complaints and Appeals

Molina Healthcare provides to the Member and/or his/her representative, the opportunity before and during the appeal process, to examine the case file, including medical records and other documents and records considered during the appeal process that are not considered as confidential or privileged information. Molina Healthcare will include as parties to the complaint or appeal, the Member and his/her representative, or the legal representative of a deceased Member's estate.

- The complaint or appeal will be reviewed by a committee of one or more Molina Healthcare employees, who did not participate in any previous level of review or decision-making, including staff with expertise in the issue(s) under review; and
- When resolved, the Appeals Staff will inform the Member of the outcome of the review by letter. If the Member is dissatisfied with the resolution, he/she may appeal the decision with Molina Healthcare. If dissatisfied with an appeal outcome, the Member may also appeal to HSD and request a Fair Hearing.

The written decision will include the following:

- The results of the complaint or appeal review;
- The date the review of the complaint or appeal was completed;
- All information considered in investigating the complaint or appeal;
- Findings and conclusions reached based on the investigation results; and
- Disposition of the complaint or appeal.

If a denial has been upheld in whole or in part, the following information will also be provided:

- Information regarding the fact that the Member may, with a written request, receive reasonable access to and copies of all documents relevant to the appeal as allowed by law;
- Information on the Member's right to request a Fair Hearing to appeal the decision to the HSD Hearings Bureau within ninety (90) calendar days of the decision;
- The right to request the continuation of benefits while the hearing is pending, and how to make this request; and
- A statement that the Member may be held liable for the cost of those appealed benefits if the hearing decision upholds Molina Healthcare's original decision/Adverse Benefit Action.

Requesting a Fair Hearing for Members

Members may request a Fair Hearing with HSD **after the appeals process has been exhausted with Molina Healthcare:**

Hearings Bureau
P.O. Box 2348
Santa Fe, NM 87504-2348
Santa Fe (505) 476-6213 or Toll Free (800) 432-6217, option #6
Fax: (505) 476-6215

When the HSD receives a request for a Fair Hearing to appeal Molina Healthcare's final decision, an official record of the appeal and copy of Molina Healthcare's final decision will be submitted to the HSD Hearings Bureau.

Continuation of Benefits While Awaiting the HSD Fair Hearing

Molina Healthcare will continue the Member's benefits while the appeal and/or HSD Fair Hearing process is pending at the Member's request for continuation.

The Member will be responsible for repayment of services provided to the Member if the Fair Hearing decision is not in the Member's favor.

Molina Healthcare will provide benefits until one of the following occurs:

- The Member withdraws the appeal;
- An HSD Administrative Law Judge issues a hearing decision adverse to the Member; and
- The time period of service limits of a previously authorized service has expired.

If the final resolution of the appeal is adverse to the Member, Molina Healthcare may recover the cost of the services furnished to the Member while the appeal was pending to the extent that services were furnished solely because of the benefit continuation requirement.

If Molina Healthcare or an HSD Administrative Law Judge reverses a decision to deny, limit, or delay services, and:

- If the Member did not receive the disputed services while the appeal was pending, Molina Healthcare will authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires; and/or
- If the Member received the disputed services while the appeal was pending, Molina Healthcare will pay for these services.

Time Limitations

Processing of complaints and appeals for Members must be completed within thirty (30) calendar days from the date a written or verbal complaint or appeal request is received. If a delay is incurred, the Member will be notified before the thirtieth (30) day. Molina Healthcare may extend the thirty

(30) day timeframe by fourteen (14) calendar days if the Member requests the extension, or it is demonstrated to HSD that there is need for additional information, and the extension is in the Member's best interest.

A formal Member appeal request must be filed within sixty (60) calendar days of the date of Molina Healthcare's notice of action.

Timelines for Member Appeals

Complaint or Appeal Type	When Applied	Timelines
Expedited Resolution of Appeal Reques	When taking the time for a standard resolution could seriously jeopardize the Member's life or health.	➢ 72 hours - Oral decision notice ➢ *2 calendar days from the date of the oral decision notice* - Written decision notice
Denial for an expedited resolution request	When the request for an expedited resolution does not meet expedited review guidelines.	➢ **2 calendar days** - Written confirmation and a reasonable effor to provide verbal notice ➢ **30 calendar days** - To resolve the issue
Automatic Appeal	When an expedited service authorization rendered by Molina Healthcare denies or authorizes a service in an amount, duration, or scope less than was requested by the provider.	➢ *72 hours* - ***Written decision notice and best effort to provide oral decision notice.***
Oral or Written pre- or post-service Appeal	When a Member makes an oral or written inquiry seeking to Appeal an action, the inquiry is treated as an Appeal, pre- or post-service.	➢ **5 business days** - Acknowledgement is sent to the Member after receipt of the request ➢ **30 calendar days** - To resolve the
Review Extension	When the Member requests the extension or Molina Healthcare can demonstrate the need for additional information.	➢ **14 calendar days** - To resolve. ➢ **2 business days** - Written confirmation of reason for extensio when Molina Healthcare requests the extension.
Filing limit	Applies to timeframe that an Appeal is considered.	➢ **60 calendar days** - From date of occurrence or notice of action.

Appeal Files	Applies to timeframe that Appeal files are retained.	➢ **10 years** - From final decision date

Section 20 - Provider Grievance, Reconsideration and Appeal Processes

Molina Healthcare ensures that providers may bring to its attention their concerns regarding the operation of the plan, reimbursement disputes, claims denials due to lack of prior authorization, timeliness issues, concerns regarding quality of and access to health care services, the choice of health care providers and the adequacy of the contracted network.

Provider concerns addressed here are specific to provider interests (as opposed to individual Member interests or provider issues initiated on behalf of a Member). Provider grievances and appeals are evaluated in a consistent, impartial and timely manner to ensure compliance with state and federal laws, regulations and standards.

Provider Grievances may be submitted orally by telephone, via email or in writing. **Providers may generate a grievance by calling the Molina Healthcare Member Services Department during regular business hours (855) 322-4078**

Written Provider Appeals must be submitted via the Provider Portal or fax to: **(855) 378-3643**

Grievances may be submitted for such things as a complaint about a Molina Healthcare Member or employee or about the health plan. Issues that are not related to a Molina Healthcare action are not eligible for appeal. Every effort will be made to resolve grievances at an informal level to the provider's satisfaction whenever possible.

Initial disputes/disagreements with claim payments/denial, except as noted below in #4, are handled as **a Provider Reconsideration Request (PRR**) and not considered formal appeals. (Please see the PRR Form at the end of this Section.) Examples of PRRs include:

- Disagreement with payment amount or denial of a claim; and/or;
- Claim edit disputes.

Formal Appeals include:

- Denial of a claim due to a Utilization Management decision (denial of prior authorization); and/or;
- Disagreement with a PRR decision.

Appeals must be submitted in writing to Molina Healthcare for Utilization Management issues (e.g. denials resulting from not obtaining prior authorization for some or all types of services and/or for all dates of service), and for Provider Reconsideration Requests (PRR) denials.

Registering and responding to provider grievances and appeals is performed by a member of the Appeals Department. The activities involved in registering and responding to provider grievances or appeals include the following:

- Notification of the review results in writing within thirty (30) calendar days;
- Documenting the substance of the grievance or appeal and the actions taken;
- Coordinating appeal reviews with the applicable department representative(s) responsible for the particular service(s) that are the subject of the grievance or appeal; and
- Notification to the provider of the appeal disposition.

The Appeals Department coordinates relaying provider grievance and appeal information to internal quality improvement committees.

Written notifications to the provider of appeal review determination decisions will include the following elements:

- The names and titles of the reviewers;
- A statement of the reviewer's understanding of the nature of the appeal and all pertinent facts;
- Reference to the evidence or documentation considered by the reviewer(s) in making the decision as applicable; and
- An explanation of the rationale for the reviewer's decision.

Timeline Grid

Type	Timeline
Complaints and Grievances	• Filing Limit: Ninety (90) calendar days from the date of dissatisfaction. • Resolution: No more than thirty (30) calendar days from receipt.
Appeals	• Filing Limit: Ninety (90) calendar days from the date of notice o action. • Resolution: Thirty (30) calendar days from receipt.

Appeal Process

- When a provider appeal is submitted in writing to Molina Healthcare, the resolution of the appeal will include the following:
- The Appeals Department staff member assigned to the appeal will coordinate and document the investigation of the substance of the appeal;
- Molina Healthcare will appoint one or more persons responsible for the substantive area addressed by the concern to review the appeal and will grant the reviewers the authorization to take appropriate corrective action on the issue;
- The provider is encouraged to present additional data pertinent to the appeal, including but not limited to, written materials, medical records and medical literature; and
- The Appeals Department will mail a written decision from the internal review to the provider within thirty calendar (30) days from the date the appeal is received.

Confidential Information

- When reviewing grievances and appeals, Molina Healthcare will treat all identifying information of Members in accordance with the rules and regulations of the Health Insurance Portability and Accountability Act (HIPAA), except as otherwise provided by State law and internal policy and procedure;
- To ensure confidentiality, information needed for a grievance or appeal review is available to Molina Healthcare staff member(s) who have a business need for the information, as required by HIPAA Minimum Necessary Rule guidance. In most cases, access is limited only to those staff members who are conducting the review.

The provider will not be subject to retaliation for filing a grievance or appeal.

Upon receipt, the issue is reviewed by the Appeals staff and the grievance or appeal is processed accordingly.

Molina Healthcare will maintain confidential **locked files** located in the Appeals Department, or secure electronic files, for all issues received.

Each file will identify and/or contain:

- Date the grievance or appeal was received;
- The name and address of the provider;
- The name of the person requesting the grievance or appeal or the name of the person on whose behalf the issue is being opened;
- The line of business under which the provider is contracted;
- Name of the staff member assigned to the issue;
- A description of the issue;
- Grievance or appeal type/level;
- Name of reviewer(s) and the final outcome;
- The date the issue was resolved and the date the provider was notified of the outcome; and
- Grievance and appeal files will be maintained for a period of no less than ten (10) years.

Reporting of Provider Complaints and Appeals

Provider complaints and appeals are reported to Molina Healthcare's governing body, the Board of Directors, through the Member and Provider Satisfaction Committee (MPSC) on a semi-annual basis. Complaint and appeal data is reported to HSD/MAD.

Provider Reconsideration Request Form

Please use the Molina Healthcare Provider Reconsideration Review Request (PRR) Form when submitting a claim adjustment request. This form can be accessed via the Molina Provider Portal by following this link: **PRR Form**

- A PRR Form is required for each claim;
- This form must be completely filled out, or it will be returned;
- Attach a legible copy of the claim and remittance advice;
- Upon receipt of this form and additional necessary information, the request will be reviewed and sent for processing if appropriate;
- If the request is declined, a letter will be sent with the denial reason;
- If you disagree with the PRR denial, you will have ninety (90) days from the date of the denial letter to appeal; and
- Submit the PRR Form and the necessary attachments to: **Toll free fax (855) 378-3642**

If you have any questions or need additional copies of the PRR Form, please contact Provider Services t**oll free at (855) 322-4078** and a representative will be glad to assist you.