

## **PROVIDER RESPONSIBILITIES**

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the US Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina complies with Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA) Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) and other regulatory/contract requirements. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency 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, gender, gender identity, sexual orientation, age 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.molinahealthcare.com](http://www.molinahealthcare.com).

### **Nondiscrimination of Healthcare Service Delivery**

Molina 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 website home pages. All Providers who join the Molina Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Molina requires Providers to deliver services to Molina Members without regard to race, 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. 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.

### **Section 1557 Investigations**

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

Molina Healthcare  
Civil Rights Coordinator  
200 OceanGate, Suite 100  
Long Beach, CA 90802

**Molina Healthcare of Washington, Inc.**

**Toll Free:** (866) 606-3889

**TTY/TDD:** 711

**On Line:** <https://molinahealthcare.AlertLine.com>

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

### **Molina Institute for Cultural Competency**

Molina is committed to reducing disparities. Training employees, Providers and their staff, and quality monitoring are the cornerstones of successful culturally competent service delivery. Molina founded the Molina 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 offers educational opportunities in cultural competency concepts for Providers, their staff, and Community Based Organizations. Molina conducts Provider training during Provider orientation with annual reinforcement training offered through Provider Services or online 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 website; and
4. Integration of cultural competency concepts and nondiscrimination of service delivery into Provider communications

### **Integrated Quality Improvement – Ensuring Access**

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

Molina 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.molinahealthcare.com](http://www.molinahealthcare.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 Member website.

### **Program and Policy Review Guidelines**

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

- Annual collection and analysis of race, ethnicity and language data from:
  - Eligible individuals to identify significant culturally and linguistically diverse populations 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 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 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 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.

#### Documentation

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

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

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

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

Molina will provide face-to-face service delivery for ASL to support our members 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 Member Services.

### **Facilities, Equipment and Personnel**

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

### **Provider Data Accuracy and Validation**

It is important for Providers to ensure Molina has accurate practice and business information. Accurate information allows us to better support and serve our Provider Network and Members. Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirement, as well as an NCQA required element. Invalid information can negatively impact Member access to care, Member assignments and referrals. Additionally, current information is critical for timely and accurate claims processing.

Providers must validate 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 by fax at (877) 814-0342 or via e-mail at [MHWProviderServicesInternalRep@Molinahealthcare.com](mailto:MHWProviderServicesInternalRep@Molinahealthcare.com) if your information needs to be updated or corrected.

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

Molina is required to audit and validate our Provider Network data and Provider Directories on a routine basis. As part of our validation efforts, we may reach out to our 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.

### **National Provider Identifier (NPI) HCA Billing and Non-Billing Enrollment Requirements**

Per federal regulation (42.C.F.R. 455.410(b)) providers who have a contract with the state's Medicaid agency or a contract with a Managed Care Organization (MCO) that serve Medicaid Clients must enroll with HCA under a Non billing or Billing agreement. The provider's National Provider Identifier (NPI) submitted on all claims must be the NPI registered with HCA.

Effective January 1, 2018, Molina will deny/reject all claims submitted to Molina for processing if billed with an NPI that is not enrolled with HCA or does not match what HCA identifies as the enrolled NPI number.

For additional information and to access the Non-Billing and Billing and servicing enrollment form, which must be used to register with HCA or to correct an NPI, visit the HCA website at <http://www.hca.wa.gov/billers-providers/apple-health-medicaid-providers/enroll-non-billing-individual-provider>.

### **Molina Electronic Solutions Requirements**

Molina requires Providers to utilize electronic solutions and tools.

Molina requires all contracted Providers to participate in and comply with Molina's Electronic Solution Requirements, which include, but are not limited to, electronic submission of prior authorization requests, 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's Provider Web Portal (Provider Portal).

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

Any Provider entering the network as a Contracted Provider will be required to comply with Molina'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/ERA payments within thirty (30) days of entering the Molina network.

If a Provider does not comply with Molina's Electronic Solution Requirements, the Provider's claim may be denied.

## Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Molina Providers include:

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

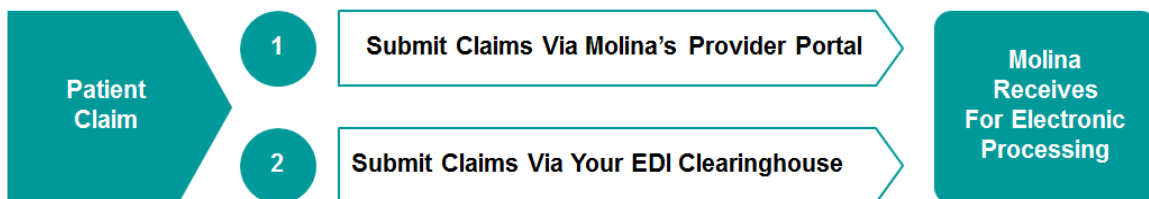
## Electronic Claims Submission Requirement

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

- Ensures 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 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 38336, refer to our website [www.molinahealthcare.com](http://www.molinahealthcare.com) for additional information.



While both options are embraced by Molina, 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 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, 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 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](http://www.molinahealthcare.com). Any questions during this process should be directed to Change Healthcare Provider Services at [wco.provider.registration@changehealthcare.com](mailto:wco.provider.registration@changehealthcare.com) or 877-389-1160.

## **Provider Web Portal**

Providers are required to register for and utilize Molina'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 services that require prior authorization. Providers may not charge Members fees for covered services.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina to the Provider. Balance billing a Molina Member for services covered by

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

**Possession of a Molina 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 are available in the Eligibility, Enrollment and Disenrollment section of this Manual.**

### **Healthcare Services (Utilization Management and Case Management)**

Providers are required to participate in and comply with Molina'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 Medical Management section of the Manual for additional details about these and other Healthcare Services programs.

### **Clinical Data Repository Participation Requirements**

Per Molina's contract with the Health Care Authority section 7.2.10.2.6 Cost to the subcontractors to program EHR systems or connect to the Health Information Exchange (HIE) are the responsibility of the individual entities. This means Molina network providers must participate in the WA Link4Health Clinical Data Repository (CDR) beginning no later than February 1, 2017 if your organization is already invested and using certified EHR technology. If



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your organization is receiving Medicaid or Medicare EHR incentive payments, it has already been determined that your system meets certification requirements. For more information you can visit:

- OneHealthPort website at <http://www.onehealthport.com/cdr-overview>
- HCA website at <https://www.hca.wa.gov/about-hca/health-information-technology/clinical-data-repository-cdr>

### **Referrals**

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

Providers should direct Members to health professionals, hospitals, laboratories, and other facilities and Providers which are contracted and credentialed (if applicable) with Molina except in the case of urgent and Emergency Services. There may be circumstances in which referrals may require an out of network Provider; prior authorization will be required from Molina except in the case of Emergency Services.

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

### **Admissions**

Providers are required to comply with Molina'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 in audits to identify, confirm, and/or assess utilization levels of covered services.

### **Continuity and Coordination of Provider Communication**

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

## **Treatment Alternatives and Communication with Members**

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

### **Prescriptions**

Providers are required to adhere to Molina'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 requires Providers to adhere to Molina's drug formularies and prescription policies designed to prevent abuse or misuse of high-risk chronic pain medication. Providers are expected to offer additional education and support to Members regarding Opioid and pain safety as needed.

Molina is dedicated to ensuring Providers are equipped with additional resources, which can be found on the Molina Provider website. Providers may access additional Opioid-safety and Substance Use Disorder resources at [www.molinahealthcare.com](http://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's Quality Programs and collaborate with Molina in conducting peer review and audits of care rendered by Providers.

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

### **Access to Care Standards**

Molina is committed to providing timely access to care for all Members in a safe and healthy environment. Molina 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. See Section 7, Quality Improvement, for the required appointment standards.

### **Site and Medical Record-Keeping Practice Reviews**

As a part of Molina's Quality Improvement Program, Providers are required to maintain compliance with certain standards for safety, confidentiality, and record keeping practices in their practices.

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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.

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.

### **PCP Role in Assessing and Referring Members for Mental Health and Chemical Dependency Services**

It is the primary care provider's (PCP) responsibility to assess if a member has any symptoms of a mental health or chemical dependency condition. If the results of the assessment are positive for mental health or chemical dependency issues, the PCP is responsible for referring the member to the appropriate mental health or chemical dependency services. In addition, it is the PCP's responsibility to support and encourage the member toward recovery and educate the member on the benefits of treating these conditions as well as the risks. Information on the principles of recovery and provider strategies to support recovery can be found on our Provider Website under page <http://store.samhsa.gov/shin/content/PEP12-RECDEF/PEP12-RECDEF.pdf>.

### **Referral for Mental Health Services**

The mental health benefit for Apple Health Medicaid beneficiaries is a two-tiered benefit. Outpatient mental health services for mild to moderate mental health conditions including psychotherapy, psychological testing, and medication management are covered under the managed care benefit. Members may also self-refer for mental health services. Please see the Molina Provider website, or contact our Molina Member Services, for a list of participating mental health providers.

More intensive mental health services for members with more severe, chronic mental health conditions, including inpatient mental health, day treatment, and intensive case management services, are provided by the Regional Support Networks (RSNs) for members who meet Access to Care Standards. The RSNs maintain a crisis/access line for members to call for services. The RSNs contract with community mental health agencies and inpatient psychiatric facilities to deliver services. The Access to Care Standards <https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/access-care-standards-acs-and-icd-information> can be located on our Provider website, as well as information on how to refer to the RSNs and a list of RSN contracted providers <https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/information-mental-health-providers>.

If you are not sure where to refer a member you may always refer to a Molina provider for an initial evaluation. The Molina case management team will identify members who may meet Access to Care Standards and coordinate a referral to the appropriate RSN. Additional information on Medicaid Mental Health services is included in the Health Care Authority Mental

Health Services Provider Guide <http://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides>.

The behavioral health benefit for FIMC Medicaid beneficiaries is the managed care plans responsibility. The managed care plan is responsible for the intensive mental health services as well as substance use disorder services. For members enrolled in AH-FIMC you would refer members to one of the in network providers located on the Molina provider online directory.

### **Referral for Chemical Dependency Services**

All Apple Health Medicaid Chemical Dependency treatment services, with the exception of medical detox in a hospital setting, are provided fee-for-service for Medicaid beneficiaries. Services are delivered by state-licensed chemical dependency providers. Information on how to refer a member for Chemical Dependency services can be found at the Alcohol and Drug Abuse Services and Information <https://www.dshs.wa.gov/bhsia/substance-use-treatment-services> link on our Provider website. For members enrolled in AH-FIMC the managed care plan is responsible for covering these services. You can refer your patient to one of our network providers located on our provider online directory. You may also contact the Healthcare Services Department at (800) 869-7185.

### **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 for use in conjunction with utilization review and management, grievances, peer review, HEDIS® Studies, Molina's Quality Programs, or claims payment. Providers will further provide direct access to patient care information (hard copy or electronic) as requested by Molina 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 Members.

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

Molina requires that contracted Providers respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member PHI.

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

### **Participation in Grievance and Appeals Programs**

Providers are required to participate in Molina's Grievance Program and cooperate with Molina in identifying, processing, and promptly resolving all Member complaints, grievances, or

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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 or statement if needed. This includes the maintenance and retention of Member records for a period of not less than ten (10) years, and retained further if the records are under review or audit until such time that the review or audit is complete.

Please refer to Section 07, Quality Improvement information regarding this program.

**Participation in Credentialing**

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

Providers must notify Molina no less than thirty (30) days in advance when they relocate or open an additional office. More information about Molina's Credentialing program, including Policies and Procedures is available in the Credentialing section of this Provider Manual.

**Delegation**

Delegated entities must comply with the terms and conditions outlined in Molina's Delegation Policies and Delegated Services Addendum. Please see Section 14, Delegation – Medical Group – IPA Operations for more information about Molina's delegation requirements and delegation oversight.