Provider Manual

Molina Healthcare of Washington, Inc.

(Molina Healthcare or Molina)

2019 Molina Medicaid

Effective January 1, 2019

Table of Contents

ADDRESSES AND PHONE NUMBERS

Please register on the Molina Healthcare Provider WebPortal at www.onehealthport.com/
By registering you can access online member eligibility, claims status, claims submission, authorization status, and authorization submission.

Member and Provider Contact Center

The Contact Center handles all telephone and written inquiries regarding claims, benefits, eligibility/identification, selecting or changing Primary Care Providers (PCPs), and Member complaints. Contact Center Representatives are available to assist Members and Providers 7:30 am to 6:30 pm Monday through Friday, excluding State holidays.

Contact Center
Address: Molina Healthcare of Washington, Inc. PO Box 4004 Bothell, WA 98041-4004
Member Phone: (800) 869-7165 Provider Phone: (855) 322-4082
TTY: 711

Claims

Molina requires Providers to submit Claims electronically through a clearinghouse or Molina's secure Provider Portal. Claims submitted electronically must use EDI payor ID number – 38336. To verify the status of your claim, please use the Provider Portal or call our Provider Contact Center Representatives at the numbers listed below. Contact Center Representatives are available 7:30am to 6:30pm Monday through Friday, excluding State holidays.

Claims
EDI Payer ID: 38336
Phone: (855) 322-4082

Claims Recovery Department

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

Claims Recovery Disputes and Refunds
Refunds Address: Molina Healthcare of Washington, Inc. PO Box 30717 Los Angeles, CA 90030-0717
Disputes

Claims Recovery Disputes and Refunds
Molina Healthcare of Washington, Inc. PO Box 2470 Spokane, WA 99210-2470
Phone: (866) 642-8999
Fax: (888) 396-1520

Contracting Department

The Contacting department should be contacted if you are interested in contracting with Molina Healthcare or checking on the status of your contract. You should notify us of any demographic updates or changes. Contracting is available 8:00am to 5:00pm Monday through Friday, excluding State holidays.

Contracting Department
Address: Molina Healthcare of Washington, Inc. PO Box 4004 Bothell, WA 98041-4004
Phone: (855) 322-4082 ex.142630
Fax: (877) 814-0542
e-mail: MHWProviderContracting@MolinaHealthcare.com

Credentialing Department

The Credentialing Department verifies all information on the Washington Practitioner 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. The Credentialing Department also performs office and medical record reviews.

Credentialing
Address: Molina Healthcare of Washington, Inc. PO Box 2470 Spokane, WA 99210-2470
Phone: (888) 562-5442
Fax: (800) 457-5213

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

HEALTHLINE **(24-Hour Nurse Advice Line)**
Phone: (888) 275-8750 (English) (866) 648-3537 (Spanish)
TTY/TDD: 711 Relay

Healthcare Services (Authorization Department)

The Healthcare Services (formerly UM) Department conducts concurrent review on inpatient cases and processes prior Authorization requests. The Healthcare Services Department also performs Case Management for members who will benefit from Case Management services.

Healthcare Services Authorizations
Address: Molina Healthcare of Washington, Inc. PO Box 4004 Bothell, WA 98041-4004
Phone: (855) 322-4082
Medical/Behavioral Services Fax: (800) 767-7188
Inpatient Census Fax: (800) 413-3806
NICU Fax: (877) 731-7220
Transplant Fax: (877) 813-1206
Advanced Imaging Fax: (877) 731-7218

EXCEPTION: *If the Member's PCP belongs to a delegated medical group/Independent Practice Association (IPA), listed in Section 14, the Provider should contact that medical group/IPA for Authorization guidance.*

Health Education and Health Management Department

The Health Education and Health Management Department provides education and health information to Molina Healthcare Members and facilitates Provider access to the program and services.

Health Education & Health Management
Address: Molina Healthcare of Washington, Inc. PO Box 2470 Spokane, WA 99210-2470
Phone: (800) 423-9899, Ext. 141453
Fax: (800) 461-3234

Pharmacy Department

Molina Healthcare's drug formulary requires prior Authorization for certain medications. The Pharmacy Department can answer questions regarding the formulary and/or drug prior Authorization requests. The Molina Healthcare formulary is available at www.MolinaHealthcare.com.

Pharmacy Authorizations
Phone: (855) 322-4082
Fax: (800) 869-7791

Caremark Pharmaceuticals

When a Molina Healthcare Member needs an injectable medication, the prescription can be submitted to Molina Healthcare by fax. For a current listing of available injectable medications, please check the web address below or use the link at www.MolinaHealthcare.com.

Caremark
Fax: (800) 869-7791
Online: https://www.caremark.com

Vision Service Plan (VSP)

Molina Healthcare is contracted with VSP to provide routine vision services for our Members. Members who are eligible may directly access a VSP network Provider.

VSP
Phone: (800) 615-1883

EXCEPTION: *If the Member's PCP belongs to a delegated medical group/IPA, listed in Section 14, the Provider should contact that medical group/IPA for Authorization guidance.*

ENROLLMENT, ELIGIBILITY AND DISENROLLMENT

Enrollment in Washington Apple Health, Apple Health Integrated Managed Care (IMC) Medicaid Programs and Behavioral Health Services Only (BHSO)

Molina Members are enrolled in a managed care health plan after the Health Care Authority (HCA) determines a Member is eligible for medical assistance through Apple Health Medicaid. Members may enroll with Molina if they reside within Molina's Service Area (please see http://www.molinahealthcare.com/providers/wa/medicaid/contacts/Pages/service_area.aspx for Molina's current Service Area). To enroll with Molina, the Member, his/her representative or his/her responsible parent/ guardian must complete and application online at www.wahealthplanfinder.org or call the Customer Support Center at (855)WAFINDER (855-923-4633) or (855) 627-9604 (TTY).

HCA will enroll all eligible Members with the health plan of their choice. If the Member does not choose a plan, HCA will assign the Member and his/her family to a plan that services the area where the Member resides. The following groups of Members, eligible for medical assistance, must enroll in a managed care plan:

- Members receiving Medicaid under the Social Security Act (SSA) provisions for coverage of families receiving Temporary Assistance for Needy Families (TANF)
- Members who are not eligible for cash assistance but remain eligible for Medicaid
- Children from birth through 18 years of age eligible for Medicaid under expanded pediatric coverage provisions of the SSA ("H" Children)
- Pregnant women eligible for Medicaid under expanded maternity coverage provisions of the SSA ("S" Women)
- Members who meet the SSA definition of blind or meet the SSA definition of persons with disabilities and are not eligible for Medicare

No eligible Member shall be refused enrollment or re-enrollment, have his/her enrollment terminated or be discriminated against in any way because of his/her health status, pre-existing physical or mental condition, including pregnancy, hospitalization or the need for frequent or high-cost care.

Effective Date of Enrollment

Earlier Enrollment allows clients to be enrolled into a plan the same month they become eligible for Medicaid, as opposed to waiting until the next month to be enrolled. Earlier enrollment applies to clients who are new to Medicaid or who have had a break in eligibility and are recertified for Medicaid services. The client will be retro effective to the first of the month they were determined eligible for Medicaid. The current month enrollment is intended to allow the client continuous enrollment in managed care from the date of enrollment. When a member changes from one health plan to the next the change will always be effective the first of the following month.

HCA notifies eligible Members of their rights and responsibilities as plan Members and sends them a booklet at the time of initial eligibility determination. Before the end of each month, HCA

sends Molina a list of assigned Members for the following month. Molina sends each new Member a Molina Member ID card and welcome letter within 15 days of initial enrollment with Molina. The letter includes important information for the new member such as how to access their online handbook and how to contact Molina.

Inpatient at time of Enrollment

Regardless of what program or health plan the Member is enrolled in at discharge (Medicaid Fee-for-Service (FFS) or an Apple Health plan), the program or plan the enrollee is enrolled with on the date of admission shall be responsible for payment of all covered inpatient facility and professional services provided from the date of admission until the date the enrollee is no longer confined to an acute care hospital or Skilled Nursing Facility or eligibility to receive Medicaid services ends.

For newborns born while their mother is hospitalized, the party responsible for the payment of covered services for the mother's hospitalization shall be responsible for payment of all covered inpatient facility and professional services provided to the newborn from the date of admission until the date the newborn is no longer confined to an acute care hospital, unless their mother is receiving FFS A newborn whose mother is receiving services when the baby is born will be enrolled on an Apple Health plan according to Earlier Enrollment rules.

When a newborn is placed in foster care, the newborns will remain enrolled with the Apple Health plan for the month of birth. The newborn will be enrolled with the Apple Health Foster Care (AHFC) program effective the first of the month following placement of the newborn. Enrollment Exemption: In some cases, a Member may request exemption from enrollment in a plan. Each request for exemption is reviewed by HCA pursuant to Washington Administration Code (WAC) 182-538-130.

Eligibility Verification

Eligibility is determined on a monthly basis. Payment for services rendered is based on eligibility and benefit entitlement. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

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

- Molina Healthcare Member ID card
- Monthly PCP eligibility listing located on the Molina Provider WebPortal
- Molina Healthcare Member Services at (800) 869-7165
- Molina Healthcare WebPortal at www.MolinaHealthcare.com / Provider Self Services
- ProviderOne website

Providers may also use a Medical Eligibility Verification (MEV) service. Molina sends eligibility information including PCP assignment to Provider Advantage and Change Health. Some MEV services provide access to online Medicaid Member eligibility data and can be purchased through approved HCA vendors. MEV services provide eligibility information for billing purposes, such as:

- Eligibility status
- Plan enrollment and plan name
- Medicare enrollment
- Availability of other insurance
- Program restriction information

HCA updates the MEV vendor list as new vendors develop MEV services. For more information and a current list of HCA vendors, please call (800) 562-3022.

Providers can also access eligibility information for Members free of charge using the ProviderOne online service. In order to access eligibility on the website you must register online and complete an application. Online enrollment information can be found at: http://www.hca.wa.gov/billers-providers/apple-health-medicaid-providers/enroll-provider

Eligibility Listing

Eligibility reports are available for viewing at any time on the Provider Web Portal at https://provider.MolinaHealthcare.com. The report includes information regarding members assigned to the PCP's at that clinic location. The eligibility reports are refreshed hourly. You can also verify a Members PCP assignment by looking up the individual member in the Web Portal. You may also call Molina's Member Services Department at (800) 869-7165 to verify eligibility.

Identification Card

An individual determined to be eligible for medical assistance is issued a ProviderOne Services Card by HCA. It is issued once upon enrollment. Providers must use the ProviderOne Client ID on the card to verify eligibility either through the ProviderOne website at https://www.waproviderone.org/ or via a Services Card swipe card reader. Providers must check Member eligibility at each visit and should make note of the following information:

- Eligibility dates (be sure to check for the current month and year)
- The ProviderOne Client ID number
- Other specific information (e.g. Medicare, Apple Health, IMC, BHSO, etc.)

Medical assistance program coverage is not transferable**.** If you suspect a Member has presented a ProviderOne (Services Card) belonging to someone else, you should request to see a photo ID or another form of identification. To report suspected Member fraud, call the Medicaid Fraud Hotline at (800) 562-6906. Do not accept a Services Card that appears to have been altered.

All Members enrolled with Molina receive an identification card from Molina in addition to the Services Card. Molina sends an identification card for each family Member covered under the plan. The Molina ID card has the name and phone number of the Member's assigned PCP.

Members are reminded to carry both ID cards (Molina ID card and Services Card) with them when requesting medical or pharmacy services. It is the Provider's responsibility to ensure Molina Members are eligible for benefits and to verify PCP assignment, prior to rendering

services. Unless an emergency condition exists, Providers may refuse service if the Member cannot produce the proper identification and eligibility cards.

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

Voluntary Disenrollment

Members may request termination of enrollment from the health plan by submitting a written request to HCA or by calling the toll-free enrollment number at (800) 562-3022. Requests for termination of enrollment may be made in order for the Member to enroll with another health plan, or disenroll from managed care completely. Members whose enrollment is terminated will be prospectively disenrolled. HCA notifies Molina of all terminations. Neither the Provider nor Molina may request voluntary disenrollment on behalf of a Member.

Involuntary Disenrollment

When a Member becomes ineligible for enrollment due to a change in eligibility status, or if the Member has comparable coverage, HCA will disenroll the Member and notify Molina.

Molina may request the involuntary termination of a Member for cause by sending a written notice to HCA. HCA will approve/disapprove the request for termination within thirty (30) working days of receipt of request. Molina must continue to provide medical services to the Member until they are disenrolled. HCA will not disenroll a Member based solely on an adverse change in the Member's health status or the cost of his/her health care needs. HCA may involuntarily terminate the Member's enrollment when Molina has substantiated all of the following in writing:

- The Member's behavior is inconsistent with Molina Healthcare's rules and regulations, such as:
  - Intentional misconduct
  - Purposely putting the safety of members, Molina Healthcare staff or providers at risk
  - Refusing to follow procedures or treatment recommended by provider and determined by Molina Medical Director to be essential to member's health and safety
- Molina Healthcare has provided a clinically appropriate evaluation to determine whether there is a treatable condition contributing to the Member's behavior and such evaluation either finds no treatable condition to be contributing or, after evaluation and treatment, the Member's behavior continues to prevent the Provider from safely or prudently providing medical care to the Member.
- The Member received written notice from Molina of its intent to request disenrollment, unless the requirement for notification has been waived by HCA because the Member's conduct presents the threat of imminent harm to others. Molina's notice to the Member must include the following:

a) The Member's right to use Molina's appeal process to review the request to terminate the enrollment
b) The Member's right to use the HCA hearing process

A Member whose enrollment is terminated at any time during the month is entitled to receive covered services at Molina's expense through the end of that month. If the Member is inpatient at an acute care hospital at the time of disenrollment, and the Member was enrolled with Molina on the date of admission, Molina and its contracted medical groups/IPAs shall be responsible for all inpatient facility and professional services from the date of admission through the date of discharge from the hospital unless eligibility to receive Medicaid services ends.

Supplemental Security Income (SSI)

SSI is a federal income supplement program funded by general tax revenues. It is designed to help aged, blind and disabled people who have little or no income and provides cash to meet basic needs for food, clothing and shelter. Members who are eligible for SSI receive medical care through Medicaid FFS and Apple Health Blind Disabled (AHBD) (only non-dual blind and disabled Members), but are not eligible for Apple Health Family (AHFAM), Apple Health with Premium (AHPREM) or Apple Health Adult (AHA).

When identified by case managers, Molina assists Members in pursuing SSI approvals. Until SSI is approved for the Member, Molina and its contracted medical groups/IPAs are financially responsible for all costs associated with medical management of the Member.

AHFAM, AHPREM and AHA adults who are determined to be SSI eligible due to being blind or disabled will prospectively change eligibility categories to AHBD (blind disabled) and will continue coverage through their designated health plan. Adults determined to be SSI eligible due to being aged will be dis-enrolled prospectively and HCA will not recoup any premiums from Molina. Molina and its contracted medical groups/IPAs will be responsible for providing services until the effective date of disenrollment.

If terminated, disenrollment processed on or before the HCA cut-off date, will occur the first day of the month following the month in which the termination is processed by HCA. If the termination is processed after the HCA cut-off date, disenrollment will occur the first day of the second month following the month in which the termination is processed by HCA.

Maternity and Newborn Coverage

Obstetrical (OB) care is covered for all Apple Health and IMC members. An Apple Health and IMC newborn is automatically covered through the end of the month in which the 21st day of life falls. Continued coverage is contingent upon the mother reporting the newborn to their Community Service Office (CSO) or logging into her Healthplanfinder account. If eligible, the newborn will receive a Services Card. If the baby is not reported, medical coverage ends at the end of the month in which the 21st day of life falls, unless the baby is in the hospital in which case coverage ends at discharge. If the mother changes health plans within the initial three months of life, the newborn's coverage will follow the mother's.

PCP Assignment

Molina Members have the right to choose their own PCP. If the Member does not choose a PCP, Molina will assign one to the Member based on reasonable proximity to the Member's home and prior assignments. Newborns are assigned to the mother's PCP through the first full month of coverage following discharge from the hospital. Newborns enrolled in a Molina Healthcare plan may receive services from any Molina Healthcare contracted PCP during the first sixty days after birth.

If a Member would like to know about a PCP's medical training, board certification, or other qualifications, the Member can call Member Services. This includes PCPs, specialists, hospitals and other Providers.

PCP Change

A Member can change their PCP at any time with the change being effective no later than the beginning of the month following the Member's request for the change. If the Member is receiving inpatient hospital services at the time of the request, the change will be effective the first of the month following discharge from the hospital. The guidelines are as follows:

1. If a Member calls to make a PCP change prior to the 15th of the month, the Member will be allowed to retroactively change their PCP to be effective the first of the current month, provided the Member is new to Molina that month.
2. If a Member calls to change the PCP and has been with Molina for over 15 days, the PCP change will be made prospectively to the first of the next month.
3. If the Member was assigned to the incorrect PCP due to Molina's error, the Member can retroactively change the PCP, effective the first of the current month.

There are two instances in which a PCP can request a change on behalf of the Member and the change can be made retroactive to the first of the month. They are:

1. The Member lives outside their PCP's service area.
2. The Member is assigned to a closed panel PCP because the Member chose the PCP on their Medicaid enrollment form.

Newborn PCP Assignment

- Newborns will be assigned to the mother's PCP through the first full month of coverage following discharge from the hospital.
- The mother may select a different PCP for her newborn effective the first full calendar month after discharge from the hospital by notifying Member Services.
- While assigned to the mother's PCP, the newborn may see the chosen PCP as long as the PCP is participating with Molina or one of the capitated medical groups/IPAs.
- Molina and its capitated medical groups/IPAs will be responsible for paying the PCP services provided during this time period.

Financial Responsibility and Medical Management Authority

If the mother's PCP is part of a contracted medical group/IPA, that group/IPA will be financially responsible for covered services and has the authority to medically manage the newborn until the end of the first full calendar month of coverage after discharge from the hospital. If a hospitalized newborn loses eligibility, the contracted medical group/IPA or Molina is responsible for coverage until the newborn is discharged from the acute care facility. A transfer from one acute care facility to another is not considered a discharge.

PCP Dismissal

A PCP may dismiss a Member from his/her practice based on the following reasons. The issues must be documented by the PCP:

- Repeated "No-Shows" for scheduled appointments
- Inappropriate behavior

This Section does not apply if the member's behavior is resulting from his or her special needs, except when his or her continued assignment to the PCP seriously impairs the PCP's ability to furnish services to either the individual member or other members. The Member must receive written notification from the PCP explaining in detail the reasons for dismissal from the practice. The provider may use the approved "PCP Member Dismissal Letter Template" located on the Molina website at www.MolinaHealthcare.com under the forms section. The PCP may use their own dismissal letter after approval by Molina. A copy of the dismissal letter should be faxed to Member Services at (800) 816-3778. Molina will contact the Member and assist in selecting a new PCP. The current PCP must provide emergency care to the Member for thirty (30) days during this transition period.

PCP Panel Closure – "New Members"

If a PCP determines that they are unable to accommodate "new" Members he or she can elect to close his or her panel. Molina must receive 30 days advance notice from the provider. Once the panel is closed, no new Members will be assigned to the PCP with the following exceptions:

- Family Members of existing Members will continue to be assigned;
- Members who were previously assigned to the PCP prior to a loss of eligibility will continue to be "reconnected" to the PCP.
- Members not currently assigned to you, but you have provided services 2 or more times in a 12 month period. The system will be automatically re-assign the member to you based on claims data.

Written correspondence is required and must include the reason and the effective date of the closure. If the panel will not be closed indefinitely, correspondence should also include the re-open date. If a reopen date for the panel is not known, a letter will need to be submitted when the office is ready to reopen the panel to new patients.

PCP Panel Closure – "New & Previously Assigned Members"

In the event a PCP determines they are unable to serve not only New Members, but also Members who have been previously assigned, the PCP must close his or her panel by providing immediate written notice to Molina.

Molina will identify those Members for potential re-assignment to an alternate PCP using the following objective criteria:

- Members were assigned to the PCP within the last 1- 6 months
- Member has never been seen by the PCP and does not have a scheduled appointment
- Member is not a Family Member of a member being actively seen by the PCP

The Member must receive written notification from the PCP explaining in detail the reasons for dismissal from the practice. The provider may use the approved "PCP Member Dismissal Letter Template" located on the Molina website at www.MolinaHealthcare.com under the forms section. The PCP may use their own dismissal letter after approval by Molina. A copy of the dismissal letter should be faxed to Member Services at (800) 816-3778. Molina will contact the Member and assist in selecting a new PCP. The current PCP must provide emergency care to the Member for thirty (30) days during this transition period.

MEMBER RIGHTS AND RESPONSIBILITIES

Providers must comply with the rights and responsibilities of Molina Members as outlined in the Molina Member Handbook and on the Molina website. The Member Handbook that is provided to Members annually is hereby incorporated into this Provider Manual. The most current Member Rights and Responsibilities can be accessed via the Handbook via the following link: https://www.MolinaHealthcare.com/members/wa/en-US/PDF/Medicaid/apple-health/Apple_Health_Member_Handbook.pdf.

Member Handbooks are available on Molina's Member Website. Member Rights and Responsibilities are outlined under the heading "Your Rights and Responsibilities" within the Member Handbook document.

State and Federal Law requires that health care Providers and health care facilities recognize Member rights while the Members are receiving medical care, and that Members respect the health care Provider's or health care facility's right to expect certain behavior on the part of the Members.

Below are the Member Rights and Responsibilities:

Molina Member Rights & Responsibilities Statement

As an enrollee, you have a right to:

- Help make decisions about your health care, including mental and substance use disorder services and refusing treatment
- Be informed about all treatment options available, regardless of cost
- Change primary care provider
- Get a second opinion from another provider in your health plan
- Get services without having to wait too long
- Be treated with respect and dignity. Discrimination is not allowed. No one can be treated differently or unfairly because of his or her race, color, national origin, gender, sexual preference, age, religion, creed, or disability.
- Speak freely about your health care and concerns without any bad results
- Have your privacy protected and information about your care kept confidential
- Ask for and get copies of your medical records
- Ask for and have corrections made to your medical records when needed
- Ask for and get information about:
    - Your health care and covered services
    - Your provider and how referrals are made to specialists and other providers
    - How we pay your providers for your medical care
    - All options for care and why you are getting certain kinds of care
    - How to get help with filing a grievance or complaint about your care
    - Our organizational structure including policies and procedures, practice guidelines, and how to recommend changes

- Receive plan policies, benefits, services and Members' Rights and Responsibilities at least yearly
- Receive a list of crisis phone numbers
- Receive help completing mental or medical advance directive forms

You have the responsibility to:

As an enrollee, you agree to:

- Help make decisions about your health care, including refusing treatment
- Keep appointments and be on time. Call your provider's office if you are going to be late or if you have to cancel the appointment.
- Give your providers information they need to be paid for providing services to you
- Bring your Services Card and health plan ID card to all of your appointments
- Learn about your health plan and what services are covered
- Use health care services when you need them
- Know your health problems and take part in agreed-upon treatment goals as much as possible
- Give your providers and Molina Healthcare complete information about your health
- Follow your provider's instructions for care that you have agreed to
- Use health care services appropriately. If you do not, you may be enrolled in the Patient Review and Coordination Program. In this program, you are assigned to one primary care provider, one pharmacy, one prescriber for controlled substances, and one hospital for non-emergency care. You must stay in the same plan for at least 12 months.
- Inform the Health Care Authority if your family size or situation changes, such as pregnancy, births, adoptions, address changes, or you become eligible for Medicare or other insurance
- Renew your coverage annually using the Washington Health Benefit Exchange at https://www.wahealthplanfinder.org, and report changes to your account such as income, marital status, births, adoptions, address changes, become eligible for Medicare or other insurance

Special Provisions for American Indians and Alaska Natives

If an American Indian/Alaska Native Enrollee indicates that he or she wishes to have an IHCP as his or her PCP, Molina must treat the IHCP as an in network PCP for the Enrollee regardless of whether or not the IHCP has entered into a subcontract with Molina.

Molina must honor the referral of an out-of-network IHCP to refer an AI/AN Enrollee to a network provider. (42 C.F.R. § 438.14(b)(6)).

In accord with the Section 5006(d) of the American Recovery and Reinvestment Act of 2009, Molina is required to allow American Indians and Alaska Natives free access to and make payments for any participating and nonparticipating IHCPs for contracted services provided to American Indian and Alaska Native Enrollees at a rate equal to the rate negotiated between the Contractor and the IHCP. If such a rate has not been negotiated, the payment is to be made at a rate that is not less than what would have otherwise been paid to a participating provider who is not an IHCP.

For Indian Health Care Providers (IHCPs) that are FQHCs, when the amount the IHCP receives from the Contractor for services to an Indian Enrollee of the Contractor's plan is less than the total amount the IHCP is entitled receive (including any supplemental payment under Section 1902(bb)(5) of the Social Security Act, the state must make a supplemental payment to the IHCP to make up the difference between the amount Molina pays and the amount the IHCP is entitled to receive as an FQHC, whether or not the IHCP has a contract with Molina. For IHCPs that are not FQHCs, when the amount the IHCP receives from Molina is less than the amount the IHCP would have received under FFS or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, the state must make a supplemental payment to the IHCP to make up the difference between the amount Molina pays and the amount the IHCP would have received under FFS or the applicable encounter rate, whether or not the IHCP has a contract with Molina.

Second Opinions

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

Women's Healthcare Services

Under Washington State Law, women must be allowed to have direct access to women's health care Providers who contract with Molina without a referral or prior authorization from PCPs.

Generally, women's health care Providers are not considered PCPs. Referrals from PCPs for women's health care services are **not** required, but the services must be obtained from a Molina network Provider. A Molina Member may seek direct care from any participating women's health care Provider for any of the following services:

- Maternity
- Gynecological
- Preventive care
- Other health problems discovered and treated during the course of the visit which are within the Provider's scope of practice

Hospitals are required to notify Molina within 24 hours, or the first business day, of any inpatient admissions (including deliveries) in order for hospital services to be covered. Prior authorization is still required for inpatient or outpatient surgeries. Please see Section 6, Medical Management for specific details.

Molina contracted Providers are also requested to notify the Healthcare Services Department at (800) 869-7185 when providing initial prenatal care to Members. This notification identifies Molina Members who may need to be monitored for high-risk pregnancies.

Family Planning Services

Molina members can self-refer to any family planning provider within the Molina provider network or to local health departments and family planning clinics paid by the State of Washington.

Enrollee Self Determination

Advance Directives are a written choice for health care. Under Washington State Law, there are two kinds of directives – Durable Power of Attorney for Health Care and Directive to Physicians. Written Advance Directives tell the PCP and other medical Providers how Members choose to receive medical care in the event they are unable to make end-of-life decisions. Each Molina Provider must honor Advance Directives to the fullest extent permitted under Washington State Law. Providers must document the presence of an Advance Directive in a prominent location of the medical record. PCPs must discuss Advance Directives with a Member and provide appropriate medical advice if the Member desires guidance or assistance. Under no circumstances may any Provider refuse to treat a Member or otherwise discriminate against a Member because the Member has completed an Advance Directive.

- **Durable Power of Attorney for Health Care –** This Advance Directive names another person to make medical decisions on behalf of Members when they cannot make the choices for themselves. It can include plans about the care a Member wants or does not want and include information concerning artificial life-support machines and organ donations. This form must be signed, dated and witnessed by a notary public to be valid.

- **Directive to Physicians (Living Will) –** This Advance Directive usually states the Member wants to die naturally without life-prolonging care and can also include information about any medical care. The form would be used if the Member could not talk and death would occur soon. This directive must be signed, dated and witnessed by two people who know the Member well but are not relatives, possible heirs, or health care Providers.

- **Physician Orders for Life Sustaining Treatment (POLST) -** The POLST form represents a way of summarizing wishes of an individual regarding life-sustaining treatment. The form is intended for any individual with a serious illness. It accomplishes two major purposes:
    - It is portable from one care setting to another and it translates wishes of an individual into actual physician orders. An attending physician, ARNP or PA-C must sign the form and assume full responsibility for its accuracy.

When There Is No Advance Directive

The Member's family and Provider will work together to decide on the best care for the Member based on information they may know about the Member's end-of-life plans.

Providers must obtain informed consent prior to treatment from enrollees or persons authorized to consent on behalf of an enrollee as described in RCW 7.70.065; comply with the provisions of the Natural Death Act (RCW 70.122) and state and federal Medicaid rules concerning Advance Directives (WAC 182-501-0125 and 42 CFR 438.6(m)); and, when appropriate, inform enrollees of their right to make anatomical gifts (Chapter 68.64 RCW).

BENEFITS AND COVERED SERVICES

This section provides an overview of the medical benefits and Covered Services for Molina Members enrolled in Washington Apple Health and Apple Health Integrated Managed Care (IMC) including:

- Apple Health with Premium (AHPREM) and Apple Health IMC with Premium (IMC-PREM)
- Apple Health Family/Pregnancy Medical (AHFAM) and IMC Family/Pregnancy Medical (IMC-AH)
- Apple Health Adult (AHA) and IMC Adult (IMC-AHA)
- Apple Health Blind Disabled (AHBD) and IMC (IMC-BD)
- Behavioral Health Services Only (BHSO)

While some benefits and Covered Services are the same, there are differences between the programs.

In addition to receiving health care services from providers who contract with Molina, Apple Health and IMC, Members may self-refer and receive certain benefits through local community resources such as the Department of Health and Community Mental Health Clinics (CMHC) for the following:

- Family Planning Services
- Immunizations
- Tuberculosis (TB) screening and follow-up care
- Sexually Transmitted Disease (STD) treatment and follow-up care
- HIV or AIDS testing
- Women's Health Services
  - Maternity services including services from a midwife
  - Breast or pelvic exams
- Crisis Response Services (IMC Members only)
  - Crisis intervention, and,
  - Evaluation and treatment services

Washington Apple Health

Is Washington Medicaid's managed care program that includes Apple Health Managed Care and Integrated Managed Care. It is a prepaid, comprehensive system of medical and health care delivery which includes preventive, primary, specialty and ancillary health services. HCA contracts with a number of health plans to provide health care to eligible Client groups.

Apple Health and IMC includes Clients eligible for:

- TANF
- Pregnant women with family incomes up to 193% of the federal poverty level (FPL)

- Children with family incomes up to 312% of FPL not eligible for other Medicaid programs Blind and Disabled (SSI) children and adults not eligible for Medicare
- Adult Medical or Medicaid Expansion up to 133% of FPL

Clients receive their health benefits by accessing care through providers who contract with a health plan.

Behavioral Health Services Only (BHSO)

BHSO is for specialty behavioral health services only. Specialty behavioral health is the term used for mental health and drug and alcohol treatment services. BHSO Members will continue to receive their physical health care benefits through other medical coverage such as; Medicare, private health insurance or the Medicaid fee-for-service network. Together with their physical health coverage, BHSO Members will have access to full coverage (physical health, specialty mental health and drug and alcohol treatment services).

Children's Health Insurance Plan (AHPREM) and (IMC-PREM)

AHPREM and IMC-PREM are a federal and state funded program, covering children under age 19, whose family's income is too high for Medicaid but below 312% of the FPL. HCA determines eligibility for AHPREM and enrolled children will be covered for a minimum of 12 months unless:

1. The family fails to pay the monthly premium for four months
2. The child's 19th birthday occurs before the end of the 12-month eligibility period
3. The child moves out of state

Molina is contracted to serve AHPREM and IMC-PREM Members in the same counties as our Apple Health and IMC service areas. Molina Members enrolled in the AHPREM and IMC-PREM program receive their health benefits by accessing care through providers contracted with the health plan.

Well Child Visits and EPSDT Guidelines

The Federal Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit requires the provision of early and periodic screening services and well care examinations to individuals from birth until twenty-one (21) years of age, with diagnosis and treatment of any health or mental health problems identified during these exams.

Molina adheres to the Bright Futures/American Academy of Pediatrics (AAP) Periodicity Schedule, found at https://www.aap.org/en-us/Documents/periodicity_schedule.pdff

The screening services include:

- Comprehensive health and developmental history (including assessment of both physical and mental health development)
- Immunizations in accordance with the most current Childhood Immunization Schedule, as appropriate
- Comprehensive unclothed physical exam

- Laboratory tests as specified by the AAP, including screening for lead poisoning
- Health education
- Vision services
- Hearing services
- Dental services

When a screening examination indicates the need for further evaluation, providers must provide diagnostic services or refer members when appropriate without delay. Providers must provide treatment or other measures (or refer when appropriate) to correct or ameliorate defects and physical and mental illness or conditions discovered by the screening services.

One of our goals at Molina is to improve children's health, as measured by our EPSDT rates. Your help with this effort is essential. If you have questions or suggestions related to well child care and EPSDT regulations, please call Member Services at (800) 869-7165.

Vaccines for Children

Since 1990, the Washington State Immunization Program has been providing vaccines to all children under the age of 19, regardless of their income level, through a combination of state and federal funds. In 1994, the federal government provided an additional funding source through the Vaccines for Children (VFC) program. The Centers for Disease Control and Prevention (CDC), which provides VFC funding, has developed strict accountability requirements from the state, local health jurisdictions, and individual providers. Molina Providers should be enrolled in the VFC program through their local health department.

State supplied vaccines are provided at no cost to enrolled providers through the local health department. Washington is a "universal vaccine distribution" state. This means no fees can be charged to patients for the vaccines themselves and no child should be denied state supplied vaccines for inability to pay an administration fee or office visit.

Molina follows HCA Medicaid Provider Guides for reimbursing a provider's administration costs. Providers must bill state-supplied vaccines with the appropriate procedure codes and a SL Modifier for identification and reporting purposes. More specific information regarding billing for state-supplied vaccines can be found on the Physician Related Services/Health Care Professional Services Provider Guide at https://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides

Emergency and Urgent Care Services

Urgent care services are covered by Molina without a referral or prior authorization. This also includes non-contracted providers outside of Molina's service area.

24-Hour Nurse Advice Line

Members may call the Nurse Advise Line anytime they are experiencing symptoms or need health care information. Registered nurses are available twenty-four (24) hours a day, seven (7) days a week, to assess symptoms and help make good health care decisions.

Nurse Advice Line (24 Hours)	
English Phone:	(888) 275-8750
Spanish Phone:	(866) 648-3537
TTY/TDD:	711 Relay

Molina is committed to helping our Members:

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

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

Washington Recovery Help Line

The Washington Recovery Help Line is the new consolidated help line for substance abuse, problem gambling and mental health, as authorized and funded by The Washington State Department of Social and Health Services' Division of Behavioral Health and Recovery. It is a 24-hour crisis intervention and referral line for those struggling with issues related to mental health, substance abuse, and problem gambling. Professionally trained volunteers and staff provide confidential support and referrals to detox, treatment, and recovery support groups. WA state residents can access services 24 hours a day at (866) 789-1511 or www.warecoveryhelpline.org.

Health Management Programs

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

Health Education/Disease Management

Molina offers programs to help our Members and their families manage a diagnosed health condition. You as a Provider also help us identify Members who may benefit from these programs. Members can request to be enrolled or dis-enrolled in these programs. Our programs include:

- Asthma management
- Diabetes management
- High blood pressure management
- Cardiovascular Disease (CVD) management/Congestive Heart Disease
- Chronic Obstructive Pulmonary Disease (COPD) management
- Depression management
- Obesity
- Weight Management

- Smoking Cessation
- Organ Transplant
- Serious and Persistent Mental Illness (SPMI) and Substance Use Disorder
- Maternity Screening and High Risk Obstetrics

For more information about our programs, please call: Health Education Department at (800) 423-9899, Ext. 141453 (TTY/TDD at 711 Relay). Visit www.MolinaHealthcare.com

Member Newsletters

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

Member Health Education Materials

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

Program Eligibility Criteria and Referral Source

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

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

Provider Participation

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

- Annual Provider feedback letters containing a list of patients identified with the relevant disease;
- Clinical resources such as patient assessment forms and diagnostic tools;
- Patient education resources;
- Provider Newsletters promoting the health management programs, including how to enroll patients and outcomes of the programs;
- Clinical Practice Guidelines; and,
- Preventive Health Guidelines;
- Additional information on health management programs is available from your local Molina
- HCS Department toll free at (855) 322-4082.

PROVIDER RESPONSIBILITIES

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
Toll Free: (866) 606-3889
TTY/TDD: 711
On Line: https://molinahealthcare.AlertLine.com
Email: civil.rights@molinahealthcare.com

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 (some changes can be made online) 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 National Provider Identifier (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 and correct most of your information. A convenient Provider web form can be found on the POD and additionally on the Provider Portal at https://provider.MolinaHealthcare.com. Or notify your Provider Services Representative by fax at (877) 814-0342 or via e-mail at MHWProviderContracting@MolinaHealthCare.com if your information needs to be updated or corrected.

Note: Some changes may impact credentialing. Providers are required to notify Molina of changes to credentialing information in accordance with the requirements outlined in the Credentialing 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, prior authorization status, health plan access to electronic medical records (EMR), electronic claims submission, electronic fund transfers (EFT), electronic remittance advice (ERA), electronic Claims Appeal and registration for and use of 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.

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

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:
- Promotes HIPAA compliance
- Helps to reduce operational costs associated with paper claims (printing, postage, etc.)
- Increases accuracy of data and efficient information delivery
- Reduces Claim 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 de 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 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:

Electronic Claims submitting benefits include:
- Ability to add attachments to claims
- Submit corrected claims
- Easily and quickly void claims
- Check claims status
- Receive timely notification of a change in status for a particular claim

- Ability to Save incomplete/un-submitted Claims
- Create/Manage Claim Templates

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

Electronic Payment (EFT/ERA) Requirement

Participating Providers are required to enroll 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.
Any questions during this process should be directed to Change Healthcare Provider Services at 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 – As well as view benefits, covered services and Member Health record.
- Member Roster – View a list of assigned membership for PCP(s)
- 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
  - Create and Manage Claim Templates
  - Open Saved Claims
- Prior Authorizations/Service Requests
  - Create and submit Service/Prior Authorization Requests
  - Check status of Service/Authorization Requests
  - Receive notification of change in status of Service/Authorization Requests
  - Create Service Request/Authorization Templates
- View HEDIS® Scores and compare to national benchmarks

- Appeals
  - Create and submit a Claim Appeal
  - Add Appeal attachments to Appeal
  - Receive Email Confirmation

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

Balance Billing

Providers contracted with Molina cannot bill the Member for any covered 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 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.

Out of Network Providers

Out of network provider must obtain prior authorization for all non-emergent services and ensure any cost to the member is no greater than it would be if services were furnished as a participating provider.

Member Rights and Responsibilities

Providers are required to 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 Link4 Health Clinical Data Repository (CDR) beginning no later than February 1, 2017 if your organization is already invested and using certified EHR technology. If 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

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 Healthcare Services section of the Manual for additional details and a description of Molina's Healthcare Services programs.

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. Each year, we review feedback received from PCPs and specialists and facilities to determine if the level of satisfaction with the information provided across settings or between Providers is sufficient.

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 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.

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.

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.

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 https://www.integration.samhsa.gov/integrated-care-models/behavioral-health-in-primary-care

Referral for Mental Health Services

Molina Healthcare covers lower intensity outpatient mental health (MH) services for mild-to-moderate mental health conditions including psychotherapy, psychological testing and medication management for AH members. If a Molina AH member needs higher intensity mental health services including inpatient mental health services, partial hospital programs and/or intensive outpatient programs, or substance use disorder (SUD) services, Molina will coordinate services with the local Behavioral Health Organization (BHO). Members can receive services through Molina while awaiting assessments and services through the BHO to ensure access to care. 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.

The behavioral health benefit for IMC 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-IMC refer members to one of the in-network providers located on the Molina provider online directory.

Wraparound with Intensive Services (WISe) Providers

WISe providers are required to follow the program, policies and procedures contained within the Department of Social and Health Services (DSHS) Wraparound with Intensive Services (WISe) Manual, which is available at : https://www.hca.wa.gov/assets/billers-and-providers/wise-wraparound-intensive-services-manual.pdf.

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 in the Substance use Disorder Program billing guide: https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules

For members enrolled in AH-IMC 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.

Confidentiality of Member Health Information 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.

Participation in Grievance and Appeals Programs

Providers are required to participate in Molina's Grievance Program and cooperate with Molina in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries. If a Member has a complaint regarding a Provider, the Provider will participate in the investigation of the grievance. If a Member 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 Complaints, Grievances and Appeals Process section of this Provider Manual for additional information,

Participation in Credentialing

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

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

Delegation

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

HEALTHCARE SERVICES

Introduction

Molina provides care management services to Molina Members using processes designed to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services. Molina utilizes an integrated care management model based upon empirically validated best practices that have demonstrated positive results. Research and experience show that a higher-touch, Member-centric care environment for at-risk Members supports better health outcomes. Elements of the Molina medical management program include Pre-service review and Organization Determination/ Authorization management that includes pre-admission, admission and inpatient review, Medical Necessity review, and restrictions on the use of non-network Providers. You can contact the Molina UM Department toll free at (800) 869-7175. The UM Department fax number is (800) 767-7188.

Utilization Management

Molina's Utilization Management (UM) program ensures appropriate and effective utilization of services. The UM team works closely with the Care Management (CM) team to ensure Members receive the support they need when moving from one care setting to another or when complexity of care and services is identified. To reflect the vital role this process plays in Molina's innovative HCS program, the UM program ensures the service delivered is medically necessary and demonstrates an appropriate use of resources based on the levels of care needed for a Member. This program promotes the provision of quality, cost-effective and medically appropriate services that are offered across a continuum of care, integrating a range of services appropriate to meet individual needs. It maintains flexibility to adapt to changes as necessary and is designed to influence Member's care by:

- Identify medical necessity and appropriateness while managing benefits effectively and efficiently to ensure efficiency of the healthcare services across the continuum of care;
- Defining the review criteria, information sources, and processes that are used to review and approve the provision of items and services, including prescription drugs;
- Coordinating, directing, and monitoring the quality and cost effectiveness of health care resource utilization while monitoring utilization practice patterns of Providers, hospitals and ancillary Providers to identify over and under service utilization;
- Implementing comprehensive processes to monitor and control the utilization of health care resources;
- Ensuring that services are available in a timely manner, in appropriate settings, and are planned, individualized, and measured for effectiveness;
- Reviewing processes to ensure care is safe and accessible;
- Ensuring that qualified health care professionals perform all components of the UM/CM processes while ensuring timely responses to Member appeals and grievances;
- Ensuring that UM decision tools are appropriately applied in determining Medical Necessity decision;
- Identify and assess the need for Case Management/Health Management through early identification of high or low service utilization and high cost, chronic or long term diseases;
- Promote health care in accordance with local, state and national standards;

- Identify events and patterns of care in which outcomes may be improved through efficiencies in UM, and to implement actions that improve performance by ensuring care is safe and accessible;
- Continually seek to improve Member and Provider satisfaction with health care and with Molina utilization processes while ensuring that UM decision tools are appropriately applied in determining medical necessity decision; and,
- Process authorization requests timely and with adherence to all regulatory and accreditation timeliness standards.

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

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

This Molina Provider Manual contains excerpts from Molina's Healthcare Services Program Description. For a complete copy of your state's Healthcare Services Program Description you can access the Molina website or contact the UM Department to receive a written copy. You can always find more information about Molina's UM including information about obtaining a copy of clinical criteria used for authorizations and how to contact a UM reviewer on Molina's website or calling the UM Department.

Molina's UM Department is designed to provide comprehensive health care management. This focus, from prevention through treatment, benefits the entire care delivery system by effectively and efficiently managing existing resources to ensure quality care. It also ensures that care is both medically necessary and demonstrates an appropriate use of resources based on the severity of illness and the site of service. Molina works in partnership with Members and Providers to promote a seamless delivery of health care services. Molina's managed care programs balance a combination of benefit design, reimbursement structure, information analysis and feedback, consumer education, and active intervention that manages cost and improves quality. Molina

maintains a medical management program to ensure patient safety as well as detect and prevent fraud, waste and abuse in its programs. The Molina medical management program also ensures that Molina only reimburses for services identified as a covered benefit and medically necessary.

Elements of the Molina medical management program include medical necessity review, prior authorization, inpatient management and restrictions on the use of non-network Providers.

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

Medical Necessity Review

Molina only reimburses for services that are Medically Necessary. To determine Medical Necessity, in conjunction with independent professional medical judgment, Molina will use nationally recognized guidelines, which include but are not limited to MCG (formerly known as Milliman Care Guidelines), McKesson InterQual®, ASAM (American Society of Addiction Medicine), 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.

All Providers must obtain authorization for specific services that require prior authorization, unless the requesting Provider is affiliated with a medical group/IPA granted "delegated" Utilization Management status (For information on contracted medical groups/IPAs that are delegated for UM please see the Delegation -Medical Group/IPA Operations section**.** If you are treating a Member assigned to a PCP in one of the delegated medical groups/IPAs, Molina Providers are required to follow their specific authorization requirements, as they may restrict their referrals to Providers within their group.

Clinical Information

Molina 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 does not accept clinical summaries, telephone summaries or inpatient case manager criteria reviews as meeting the clinical information requirements unless State or Federal regulations or the Molina Hospital or Provider Services Agreement require such documentation to be acceptable.

Prior Authorization

Molina requires prior authorization for specified services as long as the requirement complies with Federal or State regulations and the Molina Hospital or Provider Services Agreement. The list of services that require prior authorization is available in narrative form, along with a more

detailed list by CPT and HCPCS codes. Molina prior authorization documents are customarily updated quarterly, but may be updated more frequently as appropriate, and the documents are posted on the Molina website at: http://www.molinahealthcare.com/providers/wa/medicaid/forms/Pages/fuf.aspx.

Requests for prior authorizations to the UM Department may be requested by telephone, fax, mail based on the urgency of the requested service, or via the Provider Portal.

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

- Member demographic information (name, date of birth, Molina ID number, etc.)
- Clinical information sufficient to document the Medical Necessity of the requested service
- Provider demographic information (referring Provider and referred to Provider/facility)
- Requested service/procedure, including all appropriate CPT, HCPCS, and ICD-10 codes
- Location where service will be performed
- Member diagnosis (CMS-approved diagnostic and procedure code and descriptions)
- Pertinent medical history (include treatment, diagnostic tests, examination data)
- Requested Length of stay (for inpatient requests)
- Indicate if request is for expedited or standard processing

Molina will process any non-urgent requests within five (5) calendar days of the receipt of necessary information, but are allowed up to fourteen (14) calendar days, if additional information is required and requested by the Contractor within five (5) calendar days of the original receipt of the request for services. For all urgent requests, the decision must be made within forty-eight (48) hours of receipt of request.

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 does not "retroactively" authorize services that require prior authorization unless the request falls under WAC 284-43-2060 Extenuating Circumstances in Prior Authorization.

Molina will not administratively deny late notifications (requests for inpatient services greater than 24 hours or next business day from admission) when an extenuating circumstance adversely affects the ability of the participating provider or facility to request prior authorization prior to the service delivery as long as the services are covered benefits for the member and meet Molina medical necessity criteria.

Molina requires a participating provider or facility to submit documentation before a claim is submitted or within 14 days of claims submissions for consideration of prior authorization for extenuating circumstances. Submissions after this time frame will be considered an appeal and follow the timely filing for appeals submissions. When submitting your prior authorization request, clearly document the request is an Extenuating Circumstance and outline the Extenuating Circumstance in this case that prevented the provider from being able to request prior authorization or notification as required.

Providers who request Prior Authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina has a full-time Medical Director available to discuss medical necessity decisions with the requesting provider at (800) 869-7158.

Please indicate if the request is urgent or non-urgent. The Definition of expedited/urgent is when the situation where the standard time frame or decision making process could seriously jeopardize the life or health of the enrollee, or could jeopardize the enrollee's ability to regain maximum function. If the member is assigned to a delegated Medical Group/IPA, please send the prior authorization request to the Medical Group/IPA.

Requesting Prior Authorization

Provider Portal

Providers are required to use the Molina Provider Portal for prior authorization submissions whenever possible. Instructions for how to submit a prior authorization Request are available on the Molina Provider Portal. The benefits of submitting your prior authorization request through the Provider Portal are:

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

You can click on the following link to take you to the login page:
https://eportal.molinahealthcare.com/Provider/login

Fax

If the request is not on the form provided in this manual, be sure to send to the attention of the Healthcare Services Department. Please include the supporting documentation needed for Molina to make a determination along with the request to facilitate your request being made as expeditiously as possible.

- Molina Healthcare:
  Medical/Behavioral Health (800) 767-7188
  Advanced Imaging (877) 731-7218
  Inpatient Census (800) 413-3806
  NICU (877) 731-7220
  Transplant (877) 813-1206

- Kaiser Foundation Health Plan of the Northwest: (877) 800-5456

Phone

- Molina Healthcare: (855) 322-4082
- Kaiser Foundation Health Plan of the Northwest: (800) 813-2000

Mail

Prior Authorization requests for Molina and supporting documentation can be submitted via U.S. Mail at the following address:

Molina Healthcare of Washington
Attn: Healthcare Services Dept.
PO Box 4004
Bothell, WA 98041-4004

Genetic Lab Testing and Prior Authorization

Currently Molina requires prior authorization for genetic testing. Effective September 1, 2018 Molina Healthcare of Washington will require that Quest or Lab Corp be used for these lab services. If other labs are used these services will be redirected to Quest or Lab Corp. If the lab sample is in route to a lab other than Quest or Lab Corp, before the prior authorization is requested, the lab sample will need to be redirected before authorized. If an exception is required the ordering physician must send in a request along with a letter explaining why an exception should be considered. The request will be reviewed by a Medical Director.

Affirmative Statement about Incentives

Molina requires that all medical decisions are coordinated and rendered by qualified physicians and licensed staff unhindered by fiscal or administrative concerns and ensures, through communications to Providers, Members, and staff, that Molina and its delegated contractors do not use incentive arrangements to reward the restriction of medical care to Members. Furthermore, Molina affirms that all UM decision making is based only on appropriateness of care and service and existence of coverage for its Members, and not on the cost of the service to either Molina or the delegated group. Molina does not specifically reward Providers or other individuals for issuing denials of coverage or care. It is important to remember that:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Molina does not specifically reward Providers or other individuals for issuing denials of coverage or care.
- UM decision makers do not receive incentives to encourage decisions that result in underutilization.

Open Communication about Treatment

Molina prohibits contracted Providers from limiting Provider or Member communication regarding a Member's health care. Providers may freely communicate with, and act as an advocate for their patients. Molina requires provisions within Provider contracts that prohibit solicitation of Members for alternative coverage arrangements for the primary purpose of

securing financial gain. No communication regarding treatment options may be represented or construed to expand or revise the scope of benefits under a health plan or insurance contract.

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

Delegated Utilization Management Functions

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

Communication and Availability to Members and Providers

Molina HCS staff is accessible at (800) 869-7175 during normal business hours, from 7:30 a.m. to 6:30 p.m. Monday – Friday excluding holidays for information and authorization of care. When initiating, receiving or returning calls the UM staff will identify the organization, their name and title.

Molina's Nurse Advice Line is available to Members and Providers 24 hours a day, seven days a week at (888) 275-8750. Primary Care Physicians (PCPs) are notified via fax of all Nurse Advice Line encounters. Molina's Nurse Advice Line handles urgent and emergent after-hours UM calls. Providers can also utilize fax and the Provider Portal for after-hours UM access, as described later in this section

During business hours HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff. Callers may also contact staff directly through a private line. All staff Members identify themselves by providing their first name, job title, and organization.

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

Molina's Provider Portal is available twenty-four (24) hours per day, seven (7) days per week. The Portal can be used for Prior Authorization functions (requests, status checks, etc.) and communication.

Levels of Administrative and Clinical Review

Molina reviews and approves or denies plan coverage for various services - inpatient, outpatient, medical supplies, equipment, and selected medications. The review types are:

- Administrative (e.g., eligibility, appropriate vendor or Participating Provider, covered services) and
- Clinical (e.g., Medically Necessary)

The overall review process begins with administrative review followed by initial clinical review if appropriate. Specialist review may be needed as well. All UM requests that may lead to denial are reviewed by a heath professional at Molina (medical director, pharmacy director, or appropriately licensed health professional).

All staff involved in the review process have an updated list of services and procedures that require Pre-Service Organization Decision/Authorization.

The timelines and procedures are published in the Provider Manual and are available on the www.MolinaHealthcare.com website.

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

Emergency Services

Emergency Services means: a medical screening examination, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that Emergency Medical Condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital.

Emergency or Emergency Medical Condition means: the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including sever pain, which in the absence of immediate medical attention could reasonably be expected by a reasonable layperson, to result in jeopardy to the person's health, serious impairment of bodily functions, serious dysfunction of any bodily organ or part, or disfigurement to the person; in in the case of a pregnant woman, serious jeopardy to the health of the fetus.

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

Members accessing the emergency department inappropriately will be contacted by Molina Case Managers whenever possible to determine the reason for using Emergency Services.

Case Managers will also contact the PCP to ensure that Members are not accessing the emergency department because of an inability to be seen by the PCP.

Admissions

Hospitals are required to notify Molina within twenty four (24) hours or the first working day of any inpatient admissions, including deliveries, in order for hospital services to be covered. Prior authorization is required for inpatient or outpatient surgeries. Retroactive authorization requests for services rendered will normally not be approved.

Certified Public Expenditure (CPE) Hospitals

If your facility is identified as a CPE hospital your hospital is eligible to be compensated for inpatient services provided to the Apple Health Blind and Disabled (AHBD) or Integrated Managed Care Blind and Disabled (IMCBD) population through the certified public expenditure program. You will need to bill all inpatient services for AHBD and IMCBD members to Washington State Medicaid. In order to be compensated for services you must obtain prior authorization from the members' health plan in advance of providing the service. When you bill Washington State Medicaid you will need to include the health plan authorization number in the comments or notes section on the claim. The professional component is the responsibility of the health plan and should be billed directly to the health plan.

Inpatient Management

Elective Inpatient Admissions

Molina requires prior authorization for all elective inpatient admissions to any facility. Elective inpatient admission services performed without prior authorization may not be eligible for payment.

Emergent Inpatient Admissions

Molina requires notification of all emergent inpatient admissions within twenty-four (24) hours of admission or by the close of the next business day when emergent admissions occur on weekends or holidays. For emergency admissions, notification of the admission shall occur once the patient has been stabilized in the emergency department. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning. Molina requires that notification includes Member demographic information, facility information, date of admission and clinical information (see definition above) sufficient to document the Medical Necessity of the admission. Emergent inpatient admission services performed without meeting notification and Medical Necessity requirements or failure to include all of the needed documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient admission.

Prospective/Pre-Service Review

Pre-service review defines the process, qualified personnel and timeframes for accepting, evaluating and replying to prior authorization requests. Pre-service review is required for all non-emergent inpatient admissions, outpatient surgery and identified procedures, Home Health, some

durable medical equipment (DME) and Out-of-Area/Out-of-Network Professional Services. The pre-service review process assures the following:

- Member eligibility;
- Member covered benefits;
- The service is not experimental or investigation in nature;
- The service meets Medical Necessity criteria (according to accepted, nationally- recognized resources);
- All covered services, e.g. test, procedure, are within the Provider's scope of practice;
- The requested Provider can provide the service in a timely manner;
- The receiving specialist(s) and/or hospital is/are provided the required medical information to evaluate a Member's condition;
- The requested covered service is directed to the most appropriate contracted specialist, facility or vendor;
- The service is provided at the appropriate level of care in the appropriate facility; e.g. outpatient versus inpatient or at appropriate level of inpatient care;
- Continuity and coordination of care is maintained; and,
- The PCP is kept appraised of service requests and of the service provided to the Member by other Providers.

Inpatient Review

Molina performs concurrent inpatient review in order to ensure patient safety, Medical Necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Performing these functions requires timely clinical information updates from inpatient facilities. Molina will request updated original clinical records from inpatient facilities at regular intervals during a Member's inpatient admission. Molina requires that requested clinical information updates be received by Molina from the inpatient facility within twenty-four (24) hours of the request. Failure to provide timely clinical information updates may result in denial of authorization for the remainder of the inpatient admission dependent on the Provider contract terms and agreements.

Molina will authorize hospital care as an inpatient, for those stays where there is a clear expectation, and the medical record supports that reasonable expectation of an extended stay, or where observation has been tried, in those patients that require a period of treatment or assessment, pending a decision regarding the need for additional care, and the observation level of care has failed.

Inpatient Status Determinations

Molina's UM staff determine if the collected medical records and clinical information for requested services are "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of malformed body member" by meeting all coverage, coding and Medical Necessity requirements. To determine Medical Necessity, the criteria outlined under "Medical Necessity Review" will be used.

Discharge Planning

Discharge planning begins on admission, and is designed for early identification of medical/psychosocial issues that will need post-hospital intervention. The goal of discharge planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission. Upon discharge the Provider must provide Molina with Member demographic information, date of discharge, discharge plan and disposition.

Concurrent Review Nurses work closely with the hospital discharge planners to determine the most appropriate discharge setting for the patient. The concurrent review nurses review medical necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), skilled nursing facility and rehabilitative services.

Post Service Review

Post-Service Review applies when a Provider fails to seek authorization from Molina for services that require authorization. Failure to obtain authorization for an elective service that requires authorization will result in an administrative denial. Emergent services do not require authorization. Coverage of emergent services up to stabilization of the patient will be approved for payment. If the patient is subsequently admitted following emergent care services, authorization is required within one (1) business day or post stabilization stay will be denied.

Failure to obtain authorization when required will result in denial of payment for those services, unless the request falls under WAC 284-43-2060, Extenuating Circumstances in Prior Authorization or there was a Molina error, a Medical Necessity review will be performed. Decisions, in this circumstance, will be based on medical need, appropriateness of care guidelines defined by UM policies and criteria, regulation and guidance and evidence based criteria sets.

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

Hospital Readmission

Effective 01/01/2018 HCA has implemented a new readmission policy. All Medicaid health plans and FFS will follow a common policy which contains specific provider requirements in discharge and follow-up planning. Determination and recoupment will be retroactive and applies only to medically necessary readmissions. Critical Access hospitals are excluded from this policy.

Molina will perform retrospective review of hospital readmissions for members who are readmitted as an inpatient to the same or affiliated hospital within 14 calendar days.

Administrative Days

Hospitals requesting authorization of administrative days must submit a separate authorization request from the inpatient hospital stay. Molina requires the following information be included in the request for authorization:

- Current clinical data
- Submission of documented discharge/placement efforts
- Documentation of phone call and fax responses regarding placement to include specific information of contacted providers
- Documentation of specific rationale for declines related to placement
- Plan of care including specific needs and long term goals

If during the continuation of administrative days the member's condition is such that custodial care may be appropriate, you will be directed to Home and Community Services (HCS) for future discharge and placement needs. If the member's diagnosis includes chemical dependency issues, you must refer the member to Department of Social and Health Services (DSHS) for possible chemical dependency treatment.

Administrative days must be billed on a separate claim form:

- For acute care stay paid under DRG - revenue code 0191 must be billed on the claim for administrative days and the acute care stay claim must be billed with inpatient status code 30 to indicate a separate claim will be submitted for administrative days
- For per-diem - paid services bill with revenue code 0169

Non-Network Providers and Services

Molina maintains a contracted network of qualified healthcare professionals who have undergone a comprehensive credentialing process in order to provide medical care for Molina Members. Molina requires Members to receive medical care within the participating, contracted network of providers unless it is for Emergency Services as defined by Federal Law.

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

Avoiding Conflict of Interest

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

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

Coordination of Care and Services

Molina's Health Care Services (HCS) includes Utilization Management and Care Management. HCS works with Providers to assist with coordinating services and benefits for Members with complex needs. 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 staff assists Providers by identifying needs and issues that may not be verbalized by Providers, assisting to identify resources such as community programs, national support groups, appropriate specialists and facilities, identifying best practice or new and innovative approaches to care. Care coordination by Molina staff is done in partnership with Providers and Members to ensure efforts are efficient and non-duplicative.

Continuity of Care and Transition of Members

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

- Acute condition or serious chronic condition – Following termination, the terminated Provider will continue to provide covered services to the Member up to ninety (90) days or longer if necessary for a safe transfer to another Provider as determined by Molina or its delegated Medical Group/IPA.
- High risk of second or third trimester pregnancy – The terminated Provider will continue to provide services following termination until postpartum services related to delivery are completed or longer if necessary for a safe transfer.

It is also Molina's policy to allow continuity of care for new Members who become effective with Molina and meet the above conditions. All requests will be reviewed by the Medical Director. For additional information regarding continuity of care and transition of Members, please contact Molina at (800) 869-7175.

UM Decisions

A decision is any determination (e.g., an approval or denial) made by Molina or the delegated Medical Group/IPA or other delegated entity with respect to the following:

- Determination to authorize, provide or pay for services (favorable determination);
- Determination to deny requests (adverse benefit determination);
- Discontinuation of a service;
- Payment for temporarily out-of-the-area renal dialysis services;

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

All Medical Necessity requests for authorization determinations must be based on nationally recognized criteria that are supported by sound scientific, medical evidence. Clinical information used in making determinations include, but are not limited to, review of medical records, consultation with the treating Providers, and review of nationally recognized criteria. The criteria for determining medical appropriateness must be clearly documented and include procedures for applying criteria based on the needs of individual patients and characteristics of the local delivery system.

Clinical criteria does not replace State regulations when making decisions regarding appropriate medical treatment for Molina Members. Molina covers all services and items required by State.

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

Board certified licensed Providers from appropriate specialty areas must be utilized to assist in making determinations of Medical Necessity, as appropriate. All utilization decisions must be made in a timely manner to accommodate the clinical urgency of the situation, in accordance with Federal regulatory requirements and NCQA standards.

Providers can contact Molina's Healthcare Services department at (800) 869-7175 to obtain Molina's UM Criteria.

Reporting of Suspected Abuse of an Adult

A vulnerable adult is a person who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation. When working with children one may encounter situations suggesting abuse, neglect and/or unsafe living environments.

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

- Physicians, dentists, interns, residents, or nurses
- Public or private school employees or child care givers
- Psychologists, social workers, family protection workers, or family protection specialists
- Attorneys, ministers, or law enforcement officers.

Suspected abuse and/or neglect should be reported as follows:

Child Abuse:

Washington State's toll-free, 24 hour, 7 day-a-week hotline that will connect you directly to the appropriate local office to report suspected child abuse or neglect.

Hotline - call **1-866-ENDHARM** (1-866-363-4276)
TTY Callers - call **1-800-624-6186** to place a direct TTY call

Adult Abuse:

Office of the Attorney General's Vulnerable Adult Abuse reporting line at:
(866) 363-4276 (866-END-HARM).

Molina's HCS team will work with PCPs and Medical Groups/IPA and other delegated entities who are obligated to communicate with each other when there is a concern that a Member is being abused. Final actions are taken by the PCP/Medical Group/IPA, other delegated entities or other clinical personnel. Under State and Federal Law, a person participating in good faith in making a report or testifying about alleged abuse, neglect, abandonment, financial exploitation or self-neglect of a vulnerable adult in a judicial or administrative proceeding may be immune from liability resulting from the report or testimony.

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

Emergency Services

Emergency Services means: a medical screening examination, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital.

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

Molina accomplishes this service by providing 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 contracts with vendors that provide twenty-four (24) hour Emergency Services for ambulance and hospitals. An out of network Emergency

hospital stay will be covered until the Member has stabilized sufficiently to transfer to a Participating Provider facility.

Molina and its contracted Providers must provide emergency services and post-emergency stabilization and maintenance services to treat any Member with an Emergency Medical Condition in compliance with Federal Law. An Emergency Medical Condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the Member including the health of a pregnant woman and/or her unborn child in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any body part; and/or,
- Serious disfigurement.

Molina covers maintenance care and post-stabilization services which are medically necessary, non-emergency services. Molina or its delegated entity arranges for post-stabilization services to ensure that the patient remains stabilized from the time the treating hospital requests authorization until the time the patient is discharged or a contracting medical provider agrees to other arrangements.

Pre-approval of emergency services is not required. Molina requires the hospital emergency room to contact the Member's primary care Provider upon the Member's arrival at the emergency room. After stabilization of the Member, Molina requires pre-approval of further post-stabilization services by a participating Provider or other Molina representative.

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.

Care Management

Molina Care Management includes Health Management (HM) and Case Management (CM) programs. Members may qualify for HM or CM based on confirmed diagnosis or specified criteria for the programs. These comprehensive programs are available for all Members that meet the criteria for services.

PCP Responsibilities in Care Management Referrals

The Member's PCP is the primary leader of the health team involved in the coordination and direction of services for the Member. The case manager provides the PCP with reports, updates, and information regarding the Member's progress through the Care Management plan. The PCP

is responsible for the provision of preventive services and for the primary medical care of Members.

Care Manager Responsibilities

The case manager collaborates with all resources involved and the Member to develop a plan of care which includes a multidisciplinary action plan (team treatment plan), a link to the appropriate institutional and community resources, and a statement of expected outcomes. Jointly, the case manager, Providers, and the Member are responsible for implementing the plan of care. Additionally the case manager:

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

Health Management

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

Health Education/Disease Management

Molina offers programs to help our Members and their families manage a diagnosed health condition. You as a Provider also help us identify Members who may benefit from these programs. Members can request to be enrolled or dis-enrolled in these programs. Our programs include:

- Asthma management
- Diabetes management
- High blood pressure management
- Cardiovascular Disease (CVD) management/Congestive Heart Disease
- Chronic Obstructive Pulmonary Disease (COPD) management
- Depression management
- Obesity
- Weight Management
- Smoking Cessation
- Organ Transplant
- Serious and Persistent Mental Illness (SPMI) and Substance Use Disorder
- Maternity Screening and High Risk Obstetrics

For more info about our programs visit www.MolinaHealthcare.com.

Member Newsletters

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

Member Health Education Materials

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

Program Eligibility Criteria and Referral Source

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

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

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

Provider Participation

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

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

- Clinical Practice Guidelines; and,
- Preventive Health Guidelines;

Additional information on health management programs is available from your local Molina HCS Department.

Case Management (CM)

Molina provides a comprehensive Case Management (CM) program to all members who meet the criteria for services. The CM program focuses on procuring and coordinating the care, services, and resources needed by Members with complex needs through a continuum of care. Molina adheres to Case Management Society of America Standards of Practice Guidelines in its execution of the program.

The Molina case managers are licensed professionals and are educated, trained and experienced in the Case Management process. The CM program is based on a Member advocacy philosophy, designed and administered to assure the Member value-added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes.

The CM program is individualized to accommodate a Member's needs with collaboration and approval from the member's PCP. The Molina case manager will arrange individual services for members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina case manager is responsible for assessing the member's appropriateness for the CM program and for notifying the PCP of the evaluation results, as well as making a recommendation for a treatment plan.

Referral to Case Management: Members with high-risk medical conditions may be referred by their PCP or specialty care provider to the CM program. The case manager works collaboratively with all members of the health care team, including the PCP, hospital UM staff, discharge planners, specialist providers, ancillary providers, the local Health Department and other community resources. The referral source provides the case manager with demographic, health care and social data about the member being referred.

Members with the following conditions may qualify for case management and should be referred to the Molina CM Program for evaluation:
- High-risk pregnancy, including members with a history of a previous preterm delivery
- Catastrophic medical conditions (e.g. neoplasm, organ/tissue transplants)
- Chronic illness (e.g. asthma, diabetes, End Stage Renal Disease)
- Preterm births
- High-technology home care requiring more than two weeks of treatment
- Member accessing ER services inappropriately
- Children with Special Health Care Needs

Referrals to the CM program may be made by contacting Molina at: Phone: 800) 869-7185 Fax: (800) 767-7188

Medical Record Standards

The provider is responsible for maintaining an electronic or paper medical record for each individual member. Records are expected to be current, legible, detailed and organized to allow for effective and confidential patient care by all providers.

Medical records are to be stored in a secure manner that permits easy retrieval. Only authorized personnel may have access to patient medical records.

Providers will develop and implement confidentiality procedures to guard member protected health information, in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy standards and all other applicable federal and state regulations. The provider must ensure his/her staff receives periodic training regarding the confidentiality of member information.

The provider is responsible for documenting directly provided services. Such services must include, but not necessarily be limited to, family planning services, preventive services, services for the treatment of sexually transmitted diseases, ancillary services, diagnostic services and diagnostic and therapeutic services for which the member was referred to the provider.
At a minimum, each medical record must be legible and maintained in detail with the documentation outlined in section 8 (Quality Improvement) of this manual. Medical records shall be maintained in accordance with State and Federal law, and for a period not less than ten (10) years.

Medical Necessity Standards

"**Medically Necessary**" or "**Medical Necessity**" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient. This is for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. Those services must be deemed by Molina to be:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate and clinically significant, in terms of type, frequency, extent, site and duration. They are considered effective for the patient's illness, injury or disease; and,
3. Not primarily for the convenience of the patient, physician, or other health care Provider. The services must not be more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature. This literature is generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

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

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 a vendor, designated by Molina.

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

Newly FDA approved drugs are considered non-formulary and subject to non-formulary policies and other non-formulary utilization criteria until a coverage decision is rendered by the Molina Pharmacy and Therapeutics Committee.

When a Molina Member needs an injectable medication, the prescription can be submitted to Molina by fax at (800) 869-7791. Specialized request forms can be obtained by calling (800) 237-2767 or at http://www.MolinaHealthcare.com/providers/wa/medicaid/forms/PDF/forms_wa_Specialtydrugre questform.pdf.

Transitions of Care

During episodes of illness involving multiple care settings, patients are at increased risk of poor health outcomes and avoidable re-admissions resulting from fragmented care if care transitions are not well executed. Molina designed its patient-centered Transitions of Care (ToC) program to improve the quality of care for patients with complex physical, long-term, and behavioral health care needs as they transition across care settings. Transitions of Care programs have been shown to reduce preventable re-admissions, emergency department use, and to improve health outcomes.

Molina defines Transitions of Care to include all services required to ensure the coordination and continuity of care from one care setting to another as the member's health status changes. This includes members discharging from medical, psychiatric, and chemical dependency inpatient treatment facilities and others. Molina's Transitions of Care team will confirm and re-establish the patient's connection to their medical home/Primary Care Physician/Specialist and assist with the coordination of care as the patient moves from one care setting to another. The target populations for Molina's Transitions of Care program are patients that are at a high risk of re-admission, based on medical literature and 30 years of experience serving the Medicaid population. These include members with a diagnosis of:

- Asthma

- Cellulitis
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Diabetes
- Pneumonia
- Chronic mental illness
- Substance abuse disorder
- Additional secondary criteria will be considered based on acuity and may include, but are not limited to, the following:
    - Member history of re-admission and poor adherence to follow-up treatment
    - Alzheimer's disease
    - Parkinson's disease
    - Multiple co-morbid conditions

Molina's ToC program focus is patient-centered collaborative care coordination. Our Transitions team works closely with Case Management, In-Patient Review Discharge Planners, Disease Management, Health Home staff, Community Health Workers, Pharmacy, providers, and care givers. This proactive collaboration helps assess for and remove barriers prior to discharge. This interdisciplinary approach ultimately results in improved health outcomes and reduced re-admissions. The ToC Team provides oversight to assure appropriate collaboration and confirms the members identified needs have been addressed. Weekly case review meetings led by a Molina Medical Director allow for discussion and planning for complex and difficult transitions.

Molina patients may be contacted by a Transitions of Care Coach via a face-to-face or telephonic visit while in the inpatient setting. The Transitions of Care coach with the facility care team works to develop an individual care transition plan and personal health record. Following discharge, the patient may receive a follow-up phone call within 2-3 days after discharge, and a face-to-face visit in their place of residence within one week after discharge if needed. The Transitions of Care Coach will assess the patient's ability to make and attend all needed follow up appointments, complete medication reconciliation, nutrition management, patients understanding of illness and how to recognize worsening symptoms, when to call their Primary Care Physician, and develop a sick day plan, assess home safety, the member's support network and community connections, and will assist the member with obtaining immediate psychosocial needs such as food, transportation, clothing, social support, advocacy, and other community-based resources. The Transitions of Care Coach will continue to provide care coordination for 4 weeks, primarily via telephone, to ensure that the goals of the individual have been met and a member has successfully transitioned to a lower level of care. As the transitions of care process nears completion, Molina's Transitions of Care coordinator will identify any on-going needs that a member may have and, if needed, coordinate a referral to the Molina Case Management program or Primary Care Physician who will work with the member to address those needs going forward.

Molina's standard of care for Transitions of Care include the following and requires these elements be completed by the facilities, Primary Care Provider, Molina Contracted Staff, Case Managers, or Molina Transitions of Care coach for each patient as they transition between care settings.

- ❖ Assess and stratify patients into levels of risk for re-admission
- ❖ Create an individual patient plan to mitigate readmission to include:
  - Patient education to support discharge care needs for example: Medication management, ensure follow up appointments are attended, self-management of conditions, when and how to seek medical care. Planning is to include caregivers as needed,
  - Written discharge plan must be given to patient/caregiver and Primary Care Provider upon discharge,
  - Provider will ensure access to follow up appointment within 7 days of discharge.
  - Schedule follow up outpatient mental health or PCP appointments within 7 calendar days of discharge or ensure Home Care services are delivered within 7 days of discharge,
  - Organize post discharge services, home care services, and therapies, etc.,
  - Telephonic reinforcement of discharge plan and needed problem solving within 2-3 business days from time of discharge,
  - Information on what to do if a problem arises following discharge,
  - For patients at high risk of re-hospitalization, provide onsite care coordinator at time of discharge (Molina may have ToC coach or contracted staff round at facility),
  - For patients at high risk of re-hospitalization, Primary Care Provider or Molina (Molina contracted staff) will visit patient residence or secondary facility such as skilled nursing facility or residential mental health facility within 7 calendar days post discharge as needed to support discharge instructions, assess environment safety, conduct medicine reconciliation, assess adequacy of support network and services, link to appropriate referrals.

Planning activity should include patient's family and caregivers and support network in assessing needs.

Members engaged in Health Homes program will receive Transitions of Care services from Health Homes Care Coordinator.

To prevent duplication of services Molina will coordinate required elements with admitting facilities and assist in providing required elements that admitting facilities are unable to provide. Molina has developed operational agreements with Regional Support Networks, targeted substance use disorder treatment facilities, long-term care facilities, and behavioral and physical health facilities to communicate and collaborate on members' transitions through different levels of care. These operational agreements include guidelines for sharing the following information:

- Notification to Molina and Primary Care Physician of member admission.
- Written discharge plan provided to both the member and Primary Care Physician.
- Discharge planning including scheduled follow-up visits.
- Coordination of services needed upon discharge.
- Notification to Molina and Primary Care Physician of discharge.

When warranted for HIPAA compliance, Molina will obtain releases from members to allow sharing of data.

Health Home Services

Health Home implementation is authorized by Section 2703 of the federal Patient Protection and Affordable Care Act, the managed fee-for-service demonstration model, and the Substitute Senate Bill 5394 from the 2011 legislative session. Under Washington State's approach, Health Homes (HH) is the bridge to integrate care within existing health delivery systems.

A Health Home is the central point for directing patient-centered care for high-risk, high-cost beneficiaries in a specified geographic coverage area. The Health Home is accountable for reducing avoidable healthcare costs, specifically preventable hospital admissions/re-admissions, and avoidable emergency room visits. The Health Homes will provide timely post-discharge follow-up with the goal to improve patient outcomes by providing intensive care coordination services to high-cost, high-need Medicaid and Medicaid/Medicare beneficiaries to ensure that services are integrated and coordinated across medical, mental health, chemical dependency, long-term services and supports, and community support services.

Molina Healthcare of Washington is a qualified Health Home (AKA "lead entity") for geographic area 1 (Clallam, Grays Harbor, Jefferson, Kitsap, Lewis, Mason, Pacific, and Thurston Counties); area 2 (Island, San Juan, Skagit, and Whatcom Counties); and area 6 (Adams, Chelan, Douglas, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, and Whitman Counties). Molina is contracted with qualified lead entities in 3 other areas across the state to provide Health Home services. King and Snohomish counties are not participating in the Health Home demonstration. As a qualified lead entity, Molina is responsible for providing (or contracting for) the following six (6) specific care coordination services functions:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitions care from inpatient to other settings, including appropriate follow-up
- Individual and family support, including authorized representatives
- Referral to community and social support services
- Use of health information technology to link services, as feasible and appropriate

As a lead entity, Molina has created integrated provider networks in the above areas to ensure physical health, mental health, chemical dependency, long term services and social support needs can be met through an integrated collaborative approach.
Molina has contracted with various qualified Care Coordination Organizations (CCO) who will hire a team of care coordination staff responsible for delivery of face-to-face interactions with qualified Health Home enrollees. Molina is also functioning as a direct (CCO) to provide direct member interactions in limited areas.

The care coordination staff will be a combined team of clinical Case Managers and non-clinical community health workers. The dedicated care coordination staff will provide individual enrollee interactions aimed at delivery through six (6) Health Home elements of care coordination (see previous description).

The Health Care Authority will determine eligibility for the Health Home program and passively enroll eligible beneficiaries into the contractor's Health Home program. Those determined eligible for Health Home must have at least one chronic condition and be at-risk of a second, as determined by a minimum predictive risk score (PRISM) of 1.5.

Every member will have the ability to consent to Health Home services, withdraw from Health Home services, or opt-out of Health Home services.

The Clinical care coordinator will be responsible for informing and coordinating services with a member's current medical team and other community support services. When your client is receiving Health Home services you will be notified by the care coordinator.
If you would like more information about Health Homes and Molina's Health Home program, information can be found at www.Molinahealthcare.com, click on the "for healthcare professionals" tab. Open the "Health Resources" tab and click the Health Home category (or follow the attached link):
http://www.MolinaHealthcare.com/providers/wa/medicaid/resource/Pages/healthhomes.aspx

Cancellation of Prior Authorized Services

Molina has implemented a process of canceling prior authorized services if the Member has lost eligibility. Molina's process is as follows:

1. Molina limits the authorization time frame to the current calendar month (i.e., all services will need to be rendered during the calendar month in which the authorization is issued); or
2. 2. Molina sends a written notice that a Member's eligibility will be terminating at the end of a given month, and any previously issued authorization(s) will be cancelled as of the last day of the month if services are not rendered by the last day of the month. This notice is sent to the rendering Provider, Member's PCP and the Member.

Second Medical/Surgical Opinion

A Member may request a second medical/surgical opinion at any time during the course of a particular treatment, in the following manner:

- Molina Members may request a second opinion about the care they are receiving at any time.
- The member may request the Second Opinion through their assigned PCP or through Molina's Member Service Department.
- Second opinion consultations with participating practitioners, arranged by the member's PCP, do not require review or prior approval by Molina.
- A Member Services representative can assist the Member in coordinating the second opinion request with the Member's PCP, specialist and/or medical group/IPA.
- An approval to a non-participating Provider will be facilitated by Molina or the medical group/IPA if the requested specialty care Provider or service is not available within the Molina network.
- The appointment for the second opinion will occur within thirty (30) days of the request. The Member may request to postpone the second opinion to a date later than 30 days.

- The Medical Director may request a second opinion at any time on any case deemed to require specialty Provider advisor review.

Providers who request prior authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina has a full-time Medical Director available to discuss medical necessity decisions with the requesting Provider at (425) 424-1100 or (800) 869-7175.

Wrong Site Surgery

If it is determined a wrong site surgery was performed, Molina will not reimburse the providers responsible for the error.

QUALITY IMPROVEMENT

Quality Improvement

Molina works with Members and Providers to maintain a comprehensive Quality Improvement Program. You can contact the Molina QI Department **toll free at** (800) 423-9899, Ext. 141428 **or fax** (800) 767-7188.

The address for mail requests is:
Molina Healthcare of Washington, Inc.
Quality Improvement Department
25140 30th DR SE Ste. 400
Bothell, WA 98021

This Provider Manual contains excerpts from the Molina Quality Improvement Program (QIP). For a complete copy of Molina QIP, you can call the telephone number above to receive a written copy.

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

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

- Have a Quality Improvement Program in place;
- Comply with and participate in Molina Quality Improvement Program including reporting of Access and Availability survey and activity results and provision of medical records as part of the HEDIS® review process and during Potential Quality of Care and/or Critical Incident investigations; and
- Allow access to Molina QI personnel for site and medical record review processes.

Patient Safety Program

Molina Healthcare's Patient Safety Program identifies appropriate safety projects and error avoidance for Molina Healthcare Members in collaboration with their Primary Care Providers. Molina Healthcare continues to support safe personal health practices for our Members through our safety program, pharmaceutical management and case management/disease management programs and education. Molina Healthcare monitors nationally recognized quality index ratings for facilities including adverse events and hospital acquired conditions as part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA), Health and Human Services (HHS) is to identify areas that have the potential for improving health care quality to reduce the incidence of events.

Quality of Care

Molina Healthcare has an established and systematic process to identify, investigate, review and report any Quality of Care, Adverse Event/Never Event, Critical Incident (as applicable), and/or service issues affecting Member care. Molina will research, resolve, track and trend issues. Confirmed Adverse Events/Never Events are reportable when related to an error in medical care that is clearly identifiable, preventable and/or found to have caused serious injury or death to a patient. Some examples of never events include:

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

Medical Records

Molina requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to Members is consistently documented and that necessary information is readily available in the medical record. All entries will be indelibly added to the Member's record. Molina conducts a medical record review of all Primary Care Providers (PCPs) that have a 50 or more Member assignment that includes the following components:

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

Medical Record Keeping Practices

Below is a list of the minimum items that are necessary in the maintenance of the Member's Medical records:

- Each patient has a separate record
- Medical records are stored away from patient areas and preferably locked
- Medical records are available at each visit and archived records are available within twenty-four (24) hours
- If hardcopy, pages are securely attached in the medical record and records are organized by dividers or color-coded when thickness of the record dictates
- If electronic, all those with access have individual passwords
- Record keeping is monitored for Quality Improvement and HIPAA compliance
- Storage maintenance for the determined timeline and disposal per record management processes
- Process for archiving medical records and implementing improvement activities
- Medical records are kept confidential and there is a process for release of medical records including behavioral health care records

Content

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

- Member name, date of birth, sex, marital status, address, employer, home and work telephone numbers, and emergency contact;
- Legible signatures and credentials of provider and other staff members within a paper chart;
- All providers who participate in the member's care;
- Information about services delivered by these providers;
- A problem list that describes the member's medical and behavioral health conditions;
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other providers;
- Prescribed medications, including dosages and dates of initial or refill prescriptions;
- Allergies and adverse reactions (or notation that none are known);
- Documentation that Advanced Directives, Power of Attorney and Living Will have been discussed with member, and a copy of Advance Directives when in place;
- Past medical and surgical history, including physical examinations, treatments, preventive services and risk factors;
- Treatment plans that are consistent with diagnosis;
- A working diagnosis that is recorded with the clinical findings;
- Pertinent history for the presenting problem;
- Pertinent physical exam for the presenting problem;
- Lab and other diagnostic tests that are ordered as appropriate by the practitioner;
- Clear and thorough progress notes that state the intent for all ordered services and treatments;
- Notations regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed, included in the next preventative care visit when appropriate;
- Notes from consultants if applicable;
- Up-to-date immunization records and documentation of appropriate history;
- All staff and provider notes are signed physically or electronically with either name or initials;
- All entries are dated;
- All abnormal lab/imaging results show explicit follow up plan(s);
- All ancillary services reports;
- Documentation of all emergency care provided in any setting;
- Documentation of all hospital admissions, inpatient and outpatient, including the hospital discharge summaries, hospital history and physicals and operative report;
- Labor and Delivery Record for any child seen since birth; and,
- A signed document stating with whom protected health information may be shared.

Organization

- The medical record is legible to someone other than the writer.
- Each patient has an individual record.
- Chart pages are bound, clipped, or attached to the file.
- Chart sections are easily recognized for retrieval of information.

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

Retrieval

- The medical record is available to Provider at each Encounter.
- The medical record is available to Molina for purposes of Quality Improvement.
- The medical record is available to the External Quality Review Organization upon request.
- The medical record is available to the Member upon their request.
- A storage system for inactive member medical records which allows retrieval within twenty four (24) hours, is consistent with State and Federal requirements, and the record is maintained for not less than ten (10) years from the last date of treatment or for a minor, one (1) year past their 20th birthday but, never less than 10 (ten) years.
- An established and functional data recovery procedure in the event of data loss.

Confidentiality

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

- Ensure that medical information is released only in accordance with applicable Federal or State law in pursuant to court orders or subpoenas;
- Maintain records and information in an accurate and timely manner;
- Ensure timely access by Members to the records and information that pertain to them;
- Abide by all Federal and State Laws regarding confidentiality and disclosure of medical records or other health an enrollment information;
- Medical Records are protected from unauthorized access;
- Access to computerized confidential information is restricted;
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information; and,
- Education and training for all staff on handling and maintaining protected health care information.

Additional information on medical records is available from your local Molina Quality Department at (800) 423-9899, Ext 141428. See also the Compliance Section of this Provider Manual for additional information regarding HIPAA.

Access to Care

Molina maintains access to care standards and processes for ongoing monitoring of access to health care (including behavioral health care) provided by contracted primary PCPs (adult and pediatric) and participating specialist (to include OB/Gyn, behavioral health practitioners, and high volume and high impact specialists). Providers are required to conform to the Access to Care appointment standards listed below to ensure that health care services are provided in a timely manner. The standards are based on ninety five percent (95%) availability for Emergency

Services and eighty percent (80%) or greater for all other services. The PCP or his/her designee must be available twenty-four (24) hours a day, seven (7) days a week to Members.

Appointment Access

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

Primary Care Appointment Type	Appointment Wait Time
Preventive Care Appointment	Within 30 calendar days of request
Second Opinions	Within 30 calendar days of request
Routine Primary Care	Within 10 calendar days of request
Urgent Care	Within 24 hours
Emergency Care	Available by phone 24 hours/seven days
After-Hours Care	Available by phone 24 hours/seven days
Office Waiting Time	Should not exceed 30 minutes
Care Transitions – PCP Visit	Within 7 calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment
Care Transitions – Home Care	If applicable, Transitional health care by a home care nurse or home care registered counselor within 7 calendar days of discharge from a substance use disorder treatment program, if ordered by the enrollee's primary care provider or as part of the discharge plan

Behavioral Health Appointment Types	Appointment Wait Time
Life Threatening	Immediately
Non-Life Threatening	Within 6 hours
Urgent Care	Within 24 hours
Routine Care	Within 10 calendar days

Additional information on appointment access standards is available from your local Molina Quality Department at (800) 423-9899.

Office Wait Time

For scheduled appointments, the wait time in offices should not exceed thirty (30) minutes. All PCPs are required to monitor waiting times and adhere to this standard.

After Hours

All Providers must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a twenty-four (24) hour phone service, seven (7) days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with an Emergency to hang-up and call 911 or go immediately to the nearest emergency room.

Appointment Scheduling

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

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

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

Women's Health Access

Molina allows Members the option to seek obstetric and gynecological care from an in-network obstetrician or gynecologist or directly from a participating PCP designated by Molina Healthcare of Washington as providing obstetrical and gynecological services. Member access to obstetrical and gynecological services is monitored to ensure Members have direct access to

Participating Providers for obstetrical and gynecological services. Gynecological services must be provided when requested regardless of the gender status of the Member.

Additional information on access to care is available under the Resources tab on the www.MolinaHealthcare.com website or from your local Molina QI Department toll free at (800) 423-9899, Ext. 141428.

Monitoring Access Standards

Access to care standards are reviewed, revised as necessary, and approved by the Quality Improvement Committee on an annual basis. Provider network adherence to access standards is monitored via the following mechanisms:

1. Provider access studies – Provider office assessment of appointment availability, and after-hours access.
2. Member complaint data – assessment of Member complaints related to access to care.
3. Member satisfaction survey – evaluation of Members' self-reported satisfaction with appointment and after-hours access.

Analysis of access data includes assessment of performance against established standards, review of trends over time, and identification of barriers. Results of analysis are reported to the Quality Improvement Committee at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for identified provider-specific or organizational trends. Performance goals are reviewed and approved annually by the Quality Improvement Committee.

Additional information on access to care is available under the Resources tab on the www.MolinaHealthcare.com website or is available from your local Molina Quality Department at (800) 423-9899, Ext. 141428.

Quality of Provider Office Sites

Molina has a process to ensure that the offices of all Providers meet its office-site and medical record keeping practices standards. Molina continually monitors Member complaints for all office sites to determine the need of an office site visit and will conduct office site visits within sixty (60) calendar days. Molina assesses the quality, safety and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This form includes the Office Site Review Guidelines and the Medical Record Keeping Practice Guidelines (as outlined above under “Medical Record Keeping Practices” and the thresholds for acceptable performance against the criteria. This includes an assessment of:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining room space
- Adequacy of medical/treatment record keeping

Physical Accessibility

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

Physical Appearance

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

Adequacy of Waiting and Examining Room Space

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

Adequacy of Medical Record-Keeping Practices

During the site-visit, Molina discusses office documentation practices with the Provider or Provider's staff. This discussion includes a review of the forms and methods used to keep the information in a consistent manner and includes how the practice ensures confidentiality of records. Molina assesses one medical/treatment record for the areas described in the Medical Records section above. To ensure Member confidentiality, Molina reviews a "blinded" medical/treatment record or a "model" record instead of an actual record.

Monitoring Office Site Review Guidelines and Compliance Standards

Provider office sites must demonstrate an overall eighty percent (80%) compliance with the "Office Site Review Guidelines" listed above. If a serious deficiency is noted during the review but the office demonstrates overall compliance, a follow-up review may be required at the discretion of the Site Reviewer to ensure correction of the deficiency.

Administration & Confidentiality of Facilities

Facilities contracted with Molina must demonstrate an overall compliance with the guidelines listed below:

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted and parking area and walkways demonstrate appropriate maintenance.
- Handicapped parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is handicapped accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two office exam rooms per physician.

- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- At least one CPR certified employee is available.
- Yearly OSHA training (Fire, Safety, Blood borne Pathogens, etc.) is documented for offices with 10 or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, and contracts evidence hazardous waste management.
- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers or labels are possible alternative methods.
- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.
- Medical records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked.
- A CLIA waiver is displayed when the appropriate lab work is run in the office.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double locked. Medication and sample access is restricted.
- System in place to ensure expired sample medications are not dispensed and injectibles and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

Improvement Plans/Corrective Action Plans

If the medical group does not achieve the required compliance with the site review standards and/or the medical record keeping practices review standards, the Site Reviewer will do all of the following:

- Send a letter to the Provider that identifies the compliance issues.
- Send sample forms and other information to assist the Provider to achieve a passing score on the next review.
- Request the Provider to submit a written corrective action plan to Molina within thirty (30) calendar days.
- Send notification that another review will be conducted of the office in six (6) months.

When compliance is not achieved, the Provider will be required to submit a written corrective action plan (CAP) to Molina within thirty (30) calendar days of notification by Molina. The request for a CAP will be sent certified mail, return receipt requested. This improvement plan should be submitted by the office manager or Provider and must include the expected time frame for completion of activities.

Additional reviews are conducted at the office at six-month intervals until compliance is achieved. At each follow-up visit a full assessment is done to ensure the office meets performance standards. The information and any response made by the Provider is included in the Provider's permanent credentials file and reported to the Credentialing Committee on the watch status report. If compliance is not attained at follow-up visits, an updated CAP will be required.

Providers who do not submit a CAP may be terminated from network participation. Any further action is conducted in accordance with the Molina Fair Hearing Plan policy.

Advance Directives (Patient Self-Determination Act)

Molina complies with the advance directives requirements of the States in which the organization provides services. Responsibilities include ensuring members receive information regarding advance directives and that contracted practitioners and facilities uphold executed documents.

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

- **Durable Power of Attorney for Health Care**: allows an agent to be appointed to carry out health care decisions
- **Living Will**: allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration
- **Guardian Appointment**: allows one to nominate someone to be appointed as Guardian if a court determines that a guardian is necessary

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

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

Members who would like more information are instructed to contact Member Services or are directed to the Caring Connections website at http://www.caringinfo.org/stateaddownload for forms available to download. Additionally, the Molina website offers information to both Providers and Members regarding advance directives, with a link to forms that can be downloaded and printed.

Molina network Providers and facilities are expected to communicate any objections they may have to a Member directive prior to service when possible. Members may select a new PCP if the assigned Provider has an objection to the Member's desired decision. Molina will facilitate finding a new PCP or specialist as needed.

In no event may any Provider refuse to treat a Member or otherwise discriminate against a Member because the Member has completed an Advance Directive. CMS Law gives Members the right to file a complaint with Molina or the State survey and certification agency if the Member is dissatisfied with Molina's handling of Advance Directives and/or if a Provider fails to comply with Advance Directives instructions.

Molina will notify the Provider via fax of an individual Member's Advance Directives identified through Care Management, Care Coordination or Case Management. Providers are instructed to

document the presence of an Advance Directive in a prominent location of the Medical Record. Auditors will also look for copies of the Advance Directive form. Advance Directives forms are State specific to meet State regulations.

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

EPSDT Services to Enrollees Under Twenty-One (21) Years

Molina maintains systematic and robust monitoring mechanisms to ensure all required Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services to Enrollees under twenty-one (21) years are timely according to required preventive guidelines. All Enrollees under twenty-one (21) years of age should receive preventive, diagnostic and treatment services at intervals as set forth in Section 1905® of the Social Security Act. Molina's Improvement Department is also available to perform Provider training to ensure that best practice guidelines are followed in relation to well child services and care for acute and chronic health care needs.

Well Child/Adolescent Visits

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

- Comprehensive health and developmental history.
- Nutritional assessment.
- Height and weight and growth charting.
- Comprehensive unclothed physical examination.
- Appropriate immunizations.
- Laboratory procedures, including lead blood level assessment appropriate for age and risk factors.
- Periodic developmental and behavioral screening.
- Vision and hearing tests.
- Dental assessment and services.
- Health education (anticipatory guidance including child development, healthy lifestyles. accident and disease prevention).

Diagnostic services, treatment, or services Medically Necessary to correct or ameliorate defects, physical or mental illnesses, and conditions discovered during a screening or testing must be provided or arranged for either directly or through referrals. Any condition discovered during the screening examination or screening test requiring further diagnostic study or treatment must be provided if within the Member's Covered Benefit Services. Members should be referred to an appropriate source of care for any required services that are not Covered Services.

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

Monitoring for Compliance with Standards

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

Quality Improvement Activities and Programs

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

Health Management

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

Care Management

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

Clinical Practice Guidelines

Molina adopts and disseminates Clinical Practice Guidelines (CPGs) to reduce inter-Provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of medical literature and/or appropriately established authority. Clinical Practice Guidelines are reviewed annually and are updated as new recommendations are published.

Molina CPGs include the following:

- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Failure
- Hypertension
- Obesity
- Detoxification and Substance Abuse
- Opioid
- Sickle Cell Disease

The adopted CPGs are distributed to the appropriate Providers, Provider groups, staff model facilities, delegates and Members by the Quality Improvement, Provider Services, Health Education and Member Services Departments. The guidelines are disseminated through Provider newsletters, Just the Fax electronic bulletins and other media and are available on the Molina Website. Individual Providers or Members may request copies from your local Molina QI Department at (800) 423-9899, Ext. 141428.

Preventive Health Guidelines

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

- Perinatal/Prenatal Care
- Care for children up to twenty-four (24) months old
- Care for children two to nineteen (2-19) years old
- Care for adults twenty to sixty-four (20-64) years old
- Care for adults sixty-five (65) years and older
- Immunization schedules for children and adolescents
- Immunization schedules for adults

All guidelines are updated with each release by USPSTF and are approved by the Quality Improvement Committee. On annual basis, Preventive Health Guidelines are distributed to Providers via www.MolinaHealthcare.com and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Provider Newsletter.

Cultural and Linguistic Services

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. For additional information

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

Measurement of Clinical and Service Quality

Molina monitors and evaluates the quality of care and services provided to Members through the following mechanisms:

- Healthcare Effectiveness Data and Information Set® (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems® (CAHPS)
- Experience of Care and Health Outcomes® (ECHO)
- Provider Satisfaction Survey
- Effectiveness of Quality Improvement Initiatives

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

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

Molina's most recent results can be obtained from your local Molina Quality staff at (800) 423-9899, Ext. 141428 or fax (800) 767-7188 or by visiting our website at www.MolinaHealthcare.com.

Healthcare Effectiveness Data and Information Set® (HEDIS)

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

HEDIS® results are used in a variety of ways. They are the measurement standard for many of Molina's clinical quality activities and health improvement programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the success of these programs.

Selected HEDIS® results are provided to regulatory and accreditation agencies as part of our contracts with these agencies. The data are also used to compare to established health plan performance benchmarks.

Consumer Assessment of Healthcare Providers and Systems® (CAHPS)

CAHPS® is the tool used by Molina to summarize Member Satisfaction with the health care and service they receive. CAHPS® examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Coordination of Care, Customer Service, Rating of Health Care and Getting Needed Prescription Drugs. The CAHPS® survey is administered annually in the spring to randomly selected Members by an NCQA©-Certified vendor.

CAHPS® results are used in much the same way as HEDIS® results, only the focus is on the service aspect of care rather than clinical activities. They form the basis for several of Molina's quality improvement activities and are used by external agencies to help ascertain the quality of services being delivered.

Experience of Care and Health Outcomes (ECHO)® Survey

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

Provider Satisfaction Survey

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

Effectiveness of Quality Improvement Initiatives

Molina monitors the effectiveness of clinical and service activities through metrics selected to demonstrate clinical outcomes and service levels. The plan's performance is compared to that of available national benchmarks indicating "best practices". The evaluation includes an assessment of clinical and service improvements on an ongoing basis. Results of these measurements guide activities for the successive periods.

In addition to the methods described above, Molina also compiles complaint and appeals data as well as on requests for out-of-network services to determine opportunities for service improvements.

What Can Providers Do?

- Ensure patients are up-to-date with their annual physical exam and preventive health screenings, including related lab orders and referrals to specialists, such as ophthalmology;
- Review the HEDIS® preventive care listing of measures for each patient to determine if anything applicable to your patients' age and/or condition has been missed;
- Check that staff is properly coding all services provided; and,
- Be sure patients understand what *they* need to do.

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

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

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

Quality Rating System

Based on Section 1311(c)(3) of the Affordable Care Act, CMS developed the Quality Rating System (QRS) to:

- Provide comparable and useful information to consumers about the quality of health care services provided by QHPs
- Facilitate oversight of QHP issuer compliance with Marketplace quality standards
- Provide actionable information for improving quality and performance

Quality ratings are calculated for each eligible QHP product using clinical quality and enrollee experience survey data. Based on results, CMS will calculate and produce quality performance ratings for each health plan on a 1- to 5- star rating scale.

Measures are organized into a hierarchical structure designed to make the QRS scores and ratings more understandable. They include, but not limited, to the following domains:

- Clinical Effectiveness
- Patient Safety
- Prevention
- Access
- Doctor and Care
- Efficiency and Affordability
- Plan Service

Clinical, Behavioral Preventive Practice Guidelines

Practice guidelines are based on scientific evidence, review of the medical literature, or appropriately established authority, as cited. All recommendations are based on published consensus guidelines and do not favor any particular treatment based solely on cost

considerations. The recommendations for care are suggested guides for making clinical decisions. Clinicians and patients must work together to develop individual treatment plans that are tailored to the specific needs and circumstances of each patient.

Molina has adopted the following clinical practice guidelines:

- Asthma
- Attention-Deficit/Hyperactivity Disorder (ADHD)
- Bipolar
- Chlamydia and Gonorrhea
- Colorectal Cancer
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Failure
- Hypertension
- Hyperlipidemia
- Judicious use of Antibiotics
- Obesity
- Prescribing Opioids for Pain
- Preventing Heart Attack and Death in Patients with Cardiovascular Disease
- Treatment of Substance Related Disorders in Children and Adolescents
- Treatment of Substance Related Disorders in Adults
- Preventive Health Guideline: Infants, Children, and Adolescents (children up to 24 months care for children 2 to 19 years of age, – 19 years old, includes Immunization.
- Preventive Health Guideline: Adults (20-64 years of age and 65 years and older, includes immunization)
- Preventive Health Guideline: Routine Prenatal Care

Additionally, to meet the EPSDT guidelines, Molina uses preventive health guidelines based on U.S. Preventive Services Task Force Recommendations.

To evaluate effectiveness, Molina measures performance against important aspects of each clinical practice and preventive guidelines using, but not limited to, the following:

- Emergency Room visit rates, if applicable
- Hospitalization Rates, if applicable
- HEDIS rates
- Member/family satisfaction with the program for those members receiving active care management.

Clinical, Behavioral, and Preventive Practice Guidelines can be reviewed from the Molina Healthcare website at the below links:
http://www.molinahealthcare.com/providers/wa/medicaid/resource/Pages/guide_clinical.aspx
and
http://www.molinahealthcare.com/providers/wa/medicaid/resource/Pages/guide_prevent.aspx

If you would like a printed copy of this information, you may request it by calling our Quality Department at (800) 869-7175 Ext. 147181.

Health Management Programs

Molina Healthcare of Washington Health Management programs provide patient education information to Members and facilitate Provider access to these chronic disease programs and services. Health Management staff; Registered Nurse, Registered Dietitian, Social Worker, and or Health Educator are available telephonically to share information about Molina Programs. They will assist Members with preventative education and management of their conditions. He/she will collaborate with the Member and Provider relating to specific needs identified for best practices. Molina requests that you as a Provider also help us identify Members who may benefit from these programs. Members can request to be enrolled or dis-enrolled in these programs. These include programs, such as:

- Asthma
- Depression

For more info about our programs, please call:

- Healthcare Services (HCS) at (800) 869-7165)
- TTY/TDD at 711 Relay
- Visit www.MolinaHealthcare.com

Program Eligibility Criteria and Referral Source

Health Management Programs are designed for Molina Members with a confirmed diagnosis. Members participate in programs for the duration of their eligibility with the plan's coverage or until the Member opts out. Each identified Member will receive specific educational materials and other resources in accordance with their assigned stratification level. Additionally, all identified Members will receive regular educational newsletters. The program model provides an "opt-out" option for Members who contact Molina Member Services and request to be removed from the program.

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

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

Provider Participation

Contracted Providers are automatically notified whenever their patients are enrolled in a health management program. Provider resources and services may include:

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

Additional information on health management programs is available from your local Molina HCS Department toll free at (800) 869-7165.

Weight Management

Given the diversity of Molina Healthcare's membership, a program created around weight management is designed to improve the quality of life among our Members and enhance clinical outcomes in the future. Helping our Members reduce unhealthy behaviors will improve their ability to manage pre-existing illnesses or chronic conditions.

Program Overview

Molina's Weight Management program is comprised of one-on-one telephonic education and coaching by a case manager to support the weight management needs of the Member. The Health Education staff work closely with the Member, providing education on nutrition, assessing the Member's readiness to lose weight, and supporting the Member throughout their participation in the Weight Management Program.

The Health Education staff work closely with the Member's Provider to implement appropriate intervention(s) for Members participating in the program. The program consists of multi-departmental coordination of services for participating Members and uses various approved health education/information resources such as: Centers For Disease Control, National Institute of Health and Clinical Care Advance system for health information (i.e. Healthwise Knowledgebase). Health Education resources are intended to provide both general telephonic health education and targeted information based on the needs of the individual.

Goals of Weight Management Program

The goals of the Weight Management program are to:

- Counsel on the health benefits of weight loss.
    - One-on-one telephonic counseling
    - BMI Identification
    - Provider and community resource referral, if available in the Member's area

- Promote Healthy Eating Habits
  - Teach basic nutrition concepts
  - Healthy Plate Method
  - Meal spacing and portion control
  - Tips on grocery shopping
  - Label reading
  - Healthy cooking method tips
  - Eating out tips
- Teach Behavior Modification techniques
  - Promote healthy lifestyle changes
  - Monitor eating behavior
  - Rewarding oneself for healthy changes and progress
- Encourage Regular Exercise
  - Advise Member to always talk to their Provider before starting any exercise program
  - Promote increased physical activity that is realistic and achievable.
  - Walking
  - Dancing
  - Sit and Be Fit program on PBS, if available in the Member's area
- Actively involve practitioners, Members, families, and other care providers in the planning, implementation, and evaluation of care.

Program Eligibility Criteria and Referral Source

Molina's Weight Management program is designed for adults who are eligible Molina Healthcare Members, 18 years of age or older upon enrollment in the program and are not actively being case managed. The proposed program model is an "invitational" design with the Member agreeing to participate in the program.

Multiple sources are used to identify potential participants. These include the following:
- Member Services – welcome calls made by staff to new Member households and incoming calls have the potential to identify eligible Members.
- Practitioner referral
- Case Management or Utilization Management review for an eligible Member who not actively being case managed.
- Member self-referral – general plan promotion of program through
- Member newsletter and other Member communications
- Nurse Advice Line services and other sources of Member/Provider contact whereby identification and referral is possible

To find out more information about the health management programs, please HCS Department toll free at (800) 869-7165.

Smoking Cessation

Molina Healthcare offers smoking cessation to all Washington Medicaid Members over the age of 18 as well as pregnant women under the age of 18 through the Quit-4-Life program at (866) 891-2320.

To know which pharmaceutical smoking cessation products and aids are available on Molina's formulary or if you would like to request approval for a product not currently on formulary, please call our pharmacy department at (800) 213-5525.

Transitions of Care (ToC)

- The Molina Healthcare TOC Program is designed to manage member transitions between levels of care to improve quality of care for members, ensure follow-care needs are met, and prevent return to higher levels of care. The program interventions include: Improving member and practitioner understanding of roles, expectations and goals; ensure the member is prepared to continue the plan of care from one setting to another; coordinate needed services with appropriate practitioners or community resources; and promote member self-management while encouraging empowerment.

- Goals of the program also include preventing avoidable hospital readmission and emergency room visits, optimal transitioning from one care setting to another and/or identifying an unexpected change in condition requiring further assessment and intervention and confirming/reestablishing the member's connection to their medical home.

- Transition services are provided telephonically or in-person depending on the level of risk of readmission. Readmission risk is assessed initially by the Inpatient Review team of nurses who manage members' admissions from admission notification to discharge. Members are contacted by a ToC coach by phone or in-person while in the facility if possible to assist with coordinating health care needs prior to discharge, then post- discharge by phone or in the member's residence to ensure a smooth transition.

For more information about this program, please call Member Services at (800) 869-7165.

Asthma Program

- Asthma Clinical Practice - These guidelines can be reviewed from the Molina Healthcare website at: http://www.MolinaHealthcare.com/providers/wa/medicaid/resource/Pages/guide_clinical.aspx
- Asthma Newsletters – Molina Healthcare distributes asthma newsletters to identified Members. You can receive a copy by calling our Quality Improvement Health Education Line at (800) 423-9899, Ext. 141428 or by going to http://www.MolinaHealthcare.com/members/wa/en-US/mem/medicaid/overvw/resources/news/Pages/mngtnews.aspx
- Smoking Cessation – Molina Healthcare offers smoking cessation to all Washington Medicaid Members over the age of 18 through the Quit-4-Life program at (866) 784-8454.

- Members can obtain additional information on Asthma on Molina Healthcare's Staying Healthy Webpage: http://www.MolinaHealthcare.com/members/common/en-US/healthy/hlthcondcare/Pages/carehealth.aspx

Healthy Living with Diabetes

Molina Healthcare has a diabetes health management program called *Healthy Living with Diabetes* designed to assist Members in understanding diabetes and self-care.

The *Healthy Living with Diabetes* program includes:

- Diabetes Clinical Practice Guidelines These guidelines can be reviewed from the Molina Healthcare website at: http://www.MolinaHealthcare.com/providers/wa/medicaid/resource/Pages/guide_clinical.aspx
- Diabetes Newsletters – Molina Healthcare distributes newsletters to diabetic Members. You can receive a copy by calling our Health Education Line at (800) 423-9899, Ext. 141428 or by going to http://www.MolinaHealthcare.com/members/wa/en-US/mem/medicaid/overvw/resources/news/Pages/mngtnews.aspx
- Diabetes Education – Diabetes education is covered for all Molina Healthcare Members. We encourage Providers to refer patients to these services, especially for newly diagnosed diabetics or those having difficulty managing their disease.
- Smoking Cessation – Molina Healthcare offers smoking cessation to all Washington Medicaid Members over the age of 18 through the Quit-4-Life program at (866) 784-8454.
- Members can obtain additional information on Diabetes on Molina Healthcare's Staying Healthy Webpage: http://www.MolinaHealthcare.com/members/common/en-US/healthy/hlthcondcare/Pages/carehealth.aspx

Heart Healthy Living Cardiovascular Program

Molina Healthcare has a Cardiovascular Health Management Program called *Heart Healthy Living* aimed at assisting Members with their understanding and management of cardiovascular disease (CVD). We have focused on five specific areas:

- Hyperlipidemia
- Congestive Heart Failure
- Hypertension
- Myocardial Infarction
- Angina

Molina Healthcare believes excellent care starts in your office. Our role is to provide additional services to complement your care.

The *Heart Healthy Living program* includes:

- Cardiovascular Disease Clinical Practice Guidelines These guidelines can be reviewed from the Molina Healthcare website at http://www.MolinaHealthcare.com/providers/wa/medicaid/resource/Pages/guide_clinical.aspx

- Smoking Cessation – Molina Healthcare offers smoking cessation to all Washington Medicaid Members over the age of 18 through the Quit-4-Life program at (866) 784-8454. We encourage providers to use this service.
- Members can obtain additional information on Cardiovascular Disease on Molina's Staying Healthy webpage: http://www.MolinaHealthcare.com/members/common/en-US/healthy/hlthcondcare/Pages/carehealth.aspx

Chronic Obstructive Pulmonary Disease program (COPD)

Molina Healthcare has a Chronic Obstructive Pulmonary Disease (COPD) Health Management Program aimed at assisting Members with their understanding and management of COPD. Molina Healthcare believes excellent care starts in your office. Our role is to provide additional services to complement your care.

COPD program includes:

- COPD Clinical Practice Guidelines These guidelines can be reviewed from the Molina Healthcare website at http://www.MolinaHealthcare.com/providers/wa/medicaid/resource/Pages/guide_clinical.aspx
- Smoking Cessation – Molina Healthcare offers smoking cessation to all Washington Medicaid Members over the age of 18 through the Quit-4-Life program at (866) 784-8454. We encourage providers to use this service.
- Members can obtain additional information on COPD on Molina's Staying Healthy webpage: http://www.MolinaHealthcare.com/members/common/en-US/healthy/hlthcondcare/Pages/carehealth.aspx

Enrollees with Special Healthcare Needs

Molina Healthcare is working toward improving care and service for Enrollees with Special Health Care Needs. Molina Healthcare in collaboration with its providers assist enrollees and families with coordination of care and to provide information regarding available resources.

Special health care needs may include but are not limited to:

- Those who have or are at increased risk of serious and/or chronic physical, developmental, behavioral or emotional conditions, substance use disorder
- Require health and related services of a type or amount beyond what is generally necessary
- Inappropriate (over and under) utilization of services including prescription use
- Specific diagnoses of children with special health care needs include: asthma, diabetes, heart disease, obesity, cancer, autism, cerebral palsy, Down's syndrome, cleft lip and/or palate, attention deficit hyperactivity disorder, prematurity, speech/language delay, sickle cell anemia, diabetes, arthritis, blindness, hearing loss, gross and/or fine motor delay and multiple sclerosis.

Providers who are caring for enrollees with Special Health Care Needs are required to develop an individualized treatment plan and coordinate care with clinical and non-clinical services, such as community resources.

The treatment plan should include the following:
- Short and long term goals
- Enrollee participation
- Modified based on enrollee's changing needs
- Barriers and how they were addressed

Case Management services are available for those Enrollees with Special Health Care Needs. Refer to Section 6, Medical Management.

Clinical, Behavioral, Preventive, Evidence-Based Practice Guidelines

Practice guidelines are based on scientific evidence, review of the medical literature, or appropriately established authority, as cited. All recommendations are based on published consensus guidelines and do not favor any particular treatment based solely on cost considerations. The recommendations for care are suggested guides for making clinical decisions. Clinicians and patients must work together to develop individual treatment plans that are tailored to the specific needs and circumstances of each patient.

Molina has adopted the following clinical practice guidelines:
- Asthma
- Attention-Deficit/Hyperactivity Disorder (ADHD)
- Bipolar
- Chlamydia and Gonorrhea
- Colorectal Cancer
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Failure
- Hypertension
- Hyperlipidemia
- Judicious use of Antibiotics
- Obesity
- Prescribing Opioids for Pain
- Preventing Heart Attack and Death in Patients with Cardiovascular Disease
- Treatment of Substance Related Disorders in Children and Adolescents
- Treatment of Substance Related Disorders in Adults
- Preventive Health Guideline: Infants, Children, and Adolescents (children up to 24 months care for children 2 to 19 years of age, – 19 years old, includes Immunization.
- Preventive Health Guideline: Adults (20-64 years of age and 65 years and older, includes immunization)
- Preventive Health Guideline: Routine Prenatal Care

Additionally, to meet the EPSDT guidelines, Molina uses preventive health guidelines based on U.S. Preventive Services Task Force Recommendations.

To evaluate effectiveness, Molina measures performance against important aspects of each clinical practice and preventive guidelines using, but not limited to, the following:

- Emergency Room visit rates, if applicable
- Hospitalization Rates, if applicable
- HEDIS rates
- Member/family satisfaction with the program for those members receiving active care management.

Clinical, Behavioral, and Preventive Practice Guidelines can be reviewed from the Molina Healthcare website at the below links:
http://www.MolinaHealthcare.com/providers/wa/medicaid/resource/Pages/guide_clinical.aspx
and
http://www.MolinaHealthcare.com/providers/wa/medicaid/resource/Pages/guide_prevent.aspx

If you would like a printed copy of this information, you may request it by calling our Quality Department at (800) 869-7175 Ext. 147181.

Clinical Incident Reporting

I. What is a Critical Incident?

- Critical Incidents are traumatic. When one of our members experiences a Critical Incident (CI), Molina is responsible for following up to ensure they have the care they need.
- CIs are reported to the Healthcare Authority (HCA) by Molina through semi-annual reporting as well as 24-hr notification to the HCA Incident Reporting System.
- In order to provide follow-up, it is important that our external provider network reports CIs to Molina as soon as the incident has been identified.

II. Critical Incident Reporting Criteria

A. A major injury or major trauma that has the potential to cause prolonged disability or death of a member that occurs in a facility that provides licensed by the state of Washington to provide publicly funded behavioral health services. An unexpected death of a member that occurs in a facility that provides licensed by the state of Washington to provide publicly funded behavioral health services

B. Violent acts allegedly committed by a member to include:
   a. Arson
   b. Assault resulting in serious bodily harm
   c. Homicide or attempted homicide by abuse
   d. Drive-by shooting
   e. Extortion
   f. Kidnapping
   g. Rape, sexual assault or indecent liberties
   h. Robbery
   i. Vehicular homicide

C. Attempted suicide & all completed suicides

D. Homicide or attempted homicide by a member

E. Abuse, neglect or exploitation of a member; not to include child abuse (APS/CPS reporting)
- NOTE: The Health Care Authority has recently announced that child abuse cases are no longer required to be reported to the Medicaid MCOs such as Molina through the Critical Incident process, but rather are reported directly to the Children's Administration/CPS as part of mandatory reporting requirements. The intent is to reduce the burden of reporting and eliminate duplicative reporting as much as possible. However if the incident also falls under one of the additional critical incident reporting criteria outlined here, it must be reported through Molina's critical incident process.
- If you have any questions please contact us at CIreporting@MolinaHealthcare.com

F. Unauthorized leave of a mentally ill offender or a sexual or violent offender from a mental health facility, secure Community Transition Facilities (i.e. Evaluation and Treatment Centers, Crisis Stabilization Units, Secure Detox Units, and Triage Facilities) that accept involuntary admissions

G. Any event involving a member that has attracted or is likely to attract media attention as it relates to the criteria stated above

III. What a Critical Incident is NOT….

A. Threatening suicide or suicidal ideation (thinking about it)
B. Routine car accidents not resulting in a serious injury
C. Accidents-minor not resulting a serious injury
D. The unexpected death or serious injury of an enrollee
E. A credible threat to enrollee safety
F. Any allegation of financial exploitation of an enrollee

IV. How do I report a Critical Incident?

A. As soon as you are notified of the critical incident
   a. Ensure member safety first, then report
   b. Some critical incidents require notification to HCA w/in 1 business day of Molina notification, so it is important that you report to Molina as soon as possible

B. Molina's Critical Incident form can be found at https://www.molinahealthcare.com/providers/wa/medicaid/forms/PDF/provider-referral-form.pdf

C. Email the completed Critical Incident form to Molina at: MHW_Critical_Incidents@MolinaHealthcare.com

D. If secure email is not available, you can fax the form to 1-800-767-7188 "Attn: Case Management"

CLAIMS AND COMPENSATION

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

- National Provider Identifier (NPI) HCA Enrollment Requirements
- Hospital Acquired Conditions and Present on Admission Program
- Claim Submission
- Coordination of Benefits (COB)
- Third Party Liability (TPL)
- Timely Claim Filing
- Claim Edit Process
- Clam Review
- Claim Auditing
- Corrected Claims
- Timely Claim Processing
- Electronic Remittance Advice and Electronic Funds Transfer
- Claim Corrections
- Overpayment and Incorrect Payment
- Claim Adjustment Disputes/Reprocessing
- Billing the Member
- Fraud and Abuse
- Encounter Data

Molina Healthcare generally follows HCA guidelines for claims processing and payment for the Apple Health (AH), Integrated Managed Care (IMC) and Behavioral Health Services Only (BHSO) Medicaid programs. These guidelines are contained in the HCA Medicaid Provider Guides. The complete guide and information on ordering a printed copy can be found at http://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides

Hospital Acquired Conditions and Present on Admission Program

The Deficit Reduction Act of 2005 (DRA) mandated that Medicare establish a program that would modify reimbursement for fee for service beneficiaries when certain conditions occurred as a direct result of a hospital stay that could have been reasonably been prevented by the use of evidenced-based guidelines. CMS titled the program “Hospital-Acquired Conditions and Present on Admission Indicator Reporting” (HAC and POA).

The following is a list of CMS Hospital Acquired Conditions. Effective October 1, 2008, CMS reduces payment for hospitalizations complicated by these categories of conditions that were not present on admission (POA):

1) Foreign Object Retained After Surgery
2) Air Embolism
3) Blood Incompatibility
4) Stage III and IV Pressure Ulcers

5) Falls and Trauma
   a) Fractures
   b) Dislocations
   c) Intracranial Injuries
   d) d) Crushing Injuries
   e) Burn
   f) Other Injuries
6) Manifestations of Poor Glycemic Control
   a) Hypoglycemic Coma
   b) Diabetic Ketoacidosis
   c) Non-Ketotic Hyperosmolar Coma
   d) Secondary Diabetes with Ketoacidosis
   e) Secondary Diabetes with Hyperosmolarity
7) Catheter-Associated Urinary Tract Infection (UTI)
8) Vascular Catheter-Associated Infection
9) Surgical Site Infection Following Coronary Artery Bypass Graft – Mediastinitis
10) Surgical Site Infection Following Certain Orthopedic Procedures:
   a) Spine
   b) Neck
   c) Shoulder
   d) Elbow
11) 11) Surgical Site Infection Following Bariatric Surgery Procedures for Obesity
   a) Laparoscopic Gastric Restrictive Surgery
   b) Laparoscopic Gastric Bypass
   c) Gastroenterostomy
12) Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)
13) Iatrogenic Pneumothorax with Venous Catheterization
14) Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
   a) Total Knee Replacement b) Hip Replacement

What this means to Providers:

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

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

Claim Submission

Providers are required to submit Claims to Molina Healthcare with appropriate documentation. Providers must follow the appropriate State and CMS Provider billing guidelines. Providers must

utilize electronic billing though a clearinghouse or Molina's Provider WebPortal, and use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims) and use electronic Payer ID number: 38336. 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.

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)
- 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

Inaccurate, incomplete, or untimely submissions and re-submissions may result in denial of the claim; and any paper claim submissions will be denied.

National Provider Identifier (NPI)

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 Healthcare 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

Electronic Claim Submissions

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 offers the following electronic Claims submission options:

- Submit Claims directly to Molina Healthcare via the secure Provider Portal
- Submit Claims to Molina via your regular EDI clearinghouse using Payer ID 38336

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 (Portal and clearinghouse submissions)
- Submit corrected claims
- Easily and quickly void claims
- Check claim status
- Receive timely notification of a change in status for a particular claim
- Submit COB Claims

Clearinghouse

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

Molina accepts EDI transactions through our gateway clearinghouse for Claims via the 837P for Professional and 837I for institutional. It is important to track your electronic

transmissions using your acknowledgement reports. The reports assure Claims are received for processing in a timely manner.

When your Claims are filed via a Clearinghouse:

- You should receive a 999 acknowledgement from your clearinghouse.
- You should also receive 277CA response file with initial status of the claims from your clearinghouse.
- You should contact your local clearinghouse representative if you experience any problems with your transmission.

EDI Claims Submission Issues

Providers who are experiencing EDI Submission issues should work with their clearinghouse to resolve the 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 claims are not accepted by Molina. Claims submitted via paper may be denied and you will need to resubmit your claim electronically for processing.

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

COB

Medicaid is the payer of last resort. Private and government carriers must be billed prior to billing Molina Healthcare or Medical groups/IPAs. Provider shall make reasonable inquiry of Members to learn whether the Member has health insurance, benefits or Covered Services other than from Molina or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Molina of said entitlement. In the event that coordination of benefits occurs, Provider shall be compensated based on the state regulatory COB methodology. Primary carrier payment information is required with the Claim submission. Providers can submit Claims with attachments, including explanation of benefits (EOBs) and other required documents, by utilizing Molina's Provider Portal. You may also submit COB claims via the clearing house by populating the appropriate segments with the primary payment information.

There are four exceptions for which Molina does not require an EOB from the primary insurance:

- Medicare is primary and the service being billed is a non-covered service by Medicare.
- The primary carrier has no available provider within a 25 mile radius of the members address. If claims are denied for this reason the provider may contact Provider Services to request the claim be processed for payment.

- The primary insurance only covers emergency services or offers limited benefits. Molina will contact the primary carrier to validate and update our systems to reflect Molina as the primary carrier.
- The member is American Indian/Alaskan Native (AI/AN).

When COB payment is as much as or more than Molina Healthcare's allowable rate and there is no patient responsibility from the primary insurance the claim has been paid in full. Molina Healthcare will make no additional payment.

When COB payment is as much as or less than Molina Healthcare's allowable rate with patient responsibility from the primary insurance, Molina Healthcare reimburses the patient responsibility not to exceed Molina Healthcare's allowable rate.

Molina Healthcare may request a refund for COB claims paid in error up to 30 months from the original paid date.

Molina Healthcare is required to notify HCA monthly when a Member is verified to have health coverage with any other health carrier, including Dual Coverage. HCA provides COB information to Molina Healthcare on a regular basis through daily enrollment files. If HCA determines the Member has Dual Coverage with Medicare, the Member will be prospectively dis-enrolled from AH and enrolled in fee-for-service Medicaid.

TPL

Molina is the payer of last resort and will make every effort to determine the appropriate third party payer for services rendered. Molina may deny Claims when Third Party has been established and will process Claims for Covered Services when probable TPL has not been established or third party benefits are not available to pay a Claim. Molina will attempt to recover any third-party resources available to Members and shall maintain records pertaining to TPL collections on behalf of Members for audit and review.

Timely Claim Filing

Provider shall promptly submit to Molina Claims for Covered Services rendered to Members. All Claims shall be submitted in a format 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 or procedures. Claims must be submitted by the Provider to Molina no later than the limitation stated in the provider contract or within 180 calendar days after discharge for inpatient services or the Date of Service for outpatient services. If Molina is not the primary payer under coordination of benefits or third party liability, Provider must submit Claims to Molina within 180 calendar days after final determination by the primary payer. Except as otherwise provided by Law or provided by Government Program requirements, any Claims that are not submitted to Molina within these timelines shall not be eligible for payment and Provider hereby waives any right to payment.

Reimbursement Guidance and Payment Guidelines

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

Molina utilizes a claims adjudication system that encompasses edits and audits that follow Washington 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). In the event a State benefit limit is more stringent/restrictive than a Federal MUE, Molina will apply the State benefit limit. Furthermore, if a professional organization has a more stringent/restrictive standard than a Federal MUE or State benefit limit, the professional organization standard may be used.
    - In the absence of State guidance, Medicare National Coverage Determinations (NCDs).
    - In the absence of State guidance, Medicare Local Coverage Determinations (LCDs).
    - Medicare 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.
- State-specific claims reimbursement guidance.
- Other coding guidelines published by industry-recognized resources.
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than State and Federal guidelines.
- Molina policies based on the appropriateness of health care and medical necessity.
- Payment policies published by Molina.

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 Centers for Medicare and Medicaid Services (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'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.

Corrected Claims

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

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:
  - "1"-ORIGINAL (initial claim)
  - "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 "1", "7" or "8" goes in the third digit for "frequency".
- In the 2300 Loop, the REF *F8 segment (claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN).

Requests for correction of claims paid by a delegated medical group/IPA must be submitted to the group responsible for payment of the original claim. See Section 14 for additional information on delegated medical group/IPA's.

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 payment schedule, Molina will process the claim for services within the minimum standards as set forth by the Office of the Insurance Commissioner (OIC) and HCA:

- Ninety-five (95%) percent of the monthly volume of "clean" claims will be adjudicated within 30 calendar days of receipt by Molina Healthcare. A "clean" claim has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.
- Ninety-five (95%) percent of the monthly volume of claims shall be paid or denied within 60 calendar days of receipt by Molina Healthcare.
- Ninety-nine (99%) percent of all claims shall be paid or denied within 90 calendar days of receipt by Molina Healthcare.

The receipt date of a claim is the date Molina Healthcare receives notice of the claim.

Electronic Claim Payment

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

To register please go to https://providernet.adminisource.com. If you have any questions regarding the registration process, please contact FIS/ProviderNet at (877) 389-1160.

Overpayments and Incorrect Payments Refund Requests

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 may request a refund for overpayments or incorrect payments on services provided within 24 months and 30 months for COB claims from the date of the original remittance advice. If a provider does not repay or dispute the overpaid amount within 45 days of the request, Molina may offset the payment amount(s) against future payments made to the provider.

If you prefer Molina offset payment on a future Remittance Advice for overpaid or incorrectly paid claims, please fax a Molina Early Reversal Permission Form to the Claims Recovery Department at (888) 396-1520.

If you have any questions regarding a refund request letter, please call the Claims Recovery Department at (866) 642-8999.

In the event the provider receives a check that is not theirs or finds an overpayment, please send the refund with a copy of the remittance advice and claim information to:
Molina Healthcare of Washington, Inc.
PO Box 30717
Los Angeles, CA 90030-0717

Billing the Member

Providers 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.

In accordance with WAC 182-502-0160, a contracted provider may only bill fee-for-service or managed care clients for covered health care services, if the Member and the provider both sign Health Care Authority form 13-879 "Agreement to Pay for Healthcare Services" no more than 90 days prior to services being rendered. The form must be completed in full. For Members with limited English proficiency, form 13-879 must be translated into the Member's primary language. If necessary, this form must also be interpreted for the Member. If the agreement is interpreted, the interpreter must also sign it. All other requirements for form 13-879 apply.

Providers must accept payment by Molina Healthcare as payment in full in accordance with 42 CFR 447.15. Balance billing is not permitted. For additional information, refer to WAC 182-502-0160 and HCA Memo #10-25.

Fraud and Abuse

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

Encounter Data

Each 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 regulatory reporting, rate setting and risk adjustment, hospital rate setting, the Quality Improvement program and HEDIS® reporting.

Encounter data must be submitted at least once per month, and within your contracts timely claims filing requirements in order to meet State and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I – Institutional, 837P – Professional, and 837D - Dental. Data must be submitted with Claims level detail for all non-institutional services provided. 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.

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

Molina 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

Please see Molina's 837P, 837I, and 837D Companion Guides with the specific submission requirements available to Providers on our website at https://www.molinahealthcare.com/providers/common/PDF/edi_comm_molina_companion_guide_5010.pdf

Behavioral Health providers will submit claims and encounter data based on the IMC SERI guide unless otherwise specified in their contract.

CREDENTIALING AND 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

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 Provider (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. 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.

Telemedicine – the practice of medicine using electronic communications, information technology, or other means between a licensee in one location, and a patient in another location with or without an intervening healthcare provider. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional encounter in person between a practitioner and a patient.

Type of Practitioners Credentialed & Recredentialed

Practitioners and groups of practitioners with whom Molina contracts must be credentialed prior to the contract being implemented. These practitioners must be licensed, certified or registered by the state to practice independently.

Providers that are licensed as organizations or facilities will be credentialed as an Organizational Provider (please refer to the policy titled Assessment of Organizational Providers). Practitioner types requiring credentialing include but are not limited to:

- Acupuncturists
- Addiction medicine specialists
- Audiologists
- Behavioral healthcare practitioners who are licensed, certified or registered by the state to practice independently
- Chiropractors
- Clinical Social Workers
- Dentists
- Licensed/Certified Midwives (Non-Nurse)
- Massage Therapists
- Medical Doctors (MD)
- Naturopathic Physicians
- Nurse Midwives
- Nurse Practitioners
- Occupational Therapists
- Optometrists
- Oral Surgeons.
- Osteopathic Physicians (DO)
- Pharmacists
- Physical Therapists
- Physician Assistants
- Podiatrists

- Psychiatrists and other physicians
- Psychologist
- Speech and Language Pathologists
- Telemedicine Practitioners

Criteria for Participation in the Molina Network

Molina has established criteria and the sources used to verify these criteria for the evaluation and selection of 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.

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 Professional Review Committee, waive any of the requirements for network participation established pursuant to these policies for good cause if it is determined that 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 Healthcare 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 Healthcare network. Providers who fail to provide proof of meeting these criteria do not have the right to submit an appeal.

- **Application** - Provider must submit to Molina a complete credentialing application and signed attestation within 180 days. Application must include all required attachments.
- **License, Certification or Registration** - Provider must hold an active, valid and unrestricted 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.
- **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.
- **Education and Training** - Providers will only be credentialed in an area of practice in which they have adequate education. Provider must have graduated from an accredited school with a degree in their designated specialty.
    - **Residency Training** - Provider must have satisfactorily completed a residency program from an accredited training program in the specialty in which they are practicing.
    - **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.

- **Board Certification -** Board certification in the specialty in which the Provider is practicing is preferred but not required. Verification of board certification is primary source verified directly with the American Board of Medical Specialties.
- **Work History -** Provider must supply most recent five (5)-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional.
- **Malpractice History -** Provider must supply a history of malpractice and professional liability claims and settlement history in accordance with the application.
- **Professional Liability Insurance –** Provider must supply current professional malpractice liability insurance coverage on application or current copy of certificate. Provider must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina Members and the provider's activities on Molina's behalf.
- **Hospital Privileges -** Practitioners must list all current hospital privileges on their credentialing application. If the practitioner has current privileges, they must be in good standing.
- **NPI -** Practitioner must have a National Provider Identifier (NPI) issued by the Centers for Medicare and Medicaid Services (CMS).
- **SSA Death Master File -** Practitioners must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File.

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 Healthcare 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 Healthcare 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 Healthcare 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 Professional Review Committee's review must be re-verified. The Professional Review 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 the contract and there was a break in service of more than thirty (30) calendar days, Molina will initially credential the Provider before the Provider rejoins the network.

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. 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.

Non-Discriminatory Credentialing and Recredentialing

Molina Healthcare does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, 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.

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 Professional Review 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.

Providers Rights during the Credentialing Process

Providers have the right to review their credentials file at any time. Provider's rights are published in the online Provider Manual for them to review at any time. A copy of the Provider Manual is also sent to the Provider at the time of initial contracting.

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 Practitioner 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 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.

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.

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

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

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

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

PROVIDER DISPUTE RESOLUTION AND MEMBER APPEALS

Who do I call for help at my health plan?

If you need help, call (800) 869-7165 or for TTD/TTY, call 711. We will keep your information private.

To file a grievance or appeal, contact:
Molina Healthcare
Attention: Member Appeals
P.O. Box 4004
Bothell, WA 98041-4004

Web: www.MolinaHealthcare.com
Phone: (800) 869-7165 / TTY 711
Fax: (877) 814-0342
Email: wamemberservices@MolinaHealthcare.com

GRIEVANCE PROCESS: How do I report a complaint?

Grievances are complaints about:

- The way you were treated,
- The quality of care or services you received,
- Problems getting care,
- Billing issues.

If you need help filing a grievance, call (800) 869-7165 / TTY 711. We will let you know we received your grievance within two business days. We will try to take care of your grievance right away. We will resolve your grievance within 45 calendar days and tell you how it was resolved.

If you are a client with behavioral health needs, the Ombuds is someone that can help you with questions and filing grievances. If you need information about how to contact your local Ombuds, call (800) 869-7165 / TTY 711 or go to https://MolinaHealthcare.com/waombuds.

APPEAL PROCESS: How do I request the review of a denied service?

An appeal is a request to review a denied service or referral. You can appeal our decision if a service was denied, reduced, or ended early. Below are the steps in the appeal process:

STEP 1: Molina Healthcare Appeal
STEP 2: State Administrative Hearing
STEP 3: Independent Review
STEP 4: Health Care Authority (HCA) Board of Appeals Review Judge

Continuation of Services During the Appeal Process

If you want to keep getting previously approved services while we review your appeal, you must file your appeal within 10 calendar days of the date on your denial letter. If the final decision in the appeal process agrees with our decision, you may need to pay for services you received during the appeal process.

STEP 1 – Molina Healthcare Appeal: How do I ask for an appeal?

You have 60 calendar days after the date of Molina Healthcare's denial letter to ask for an appeal.

You or your representative may request an appeal over the phone, in person, or in writing. If you request an appeal by phone, you must also send it in writing to us with your signature. Additional information to support your appeal may be submitted over the phone, in writing, or in person. Within five calendar days, we will let you know in writing that we got your appeal. Molina Healthcare can help you file your appeal. If you need help filing an appeal, call (800) 869-7165 / TTY 711.

STEP 1: Ask for an appeal with Molina Healthcare
Phone: (800) 869-7165 / TTY 711
Fax: (877) 814-0342
Address: P.O. Box 4004, Bothell, WA 98041-4004

You may choose someone, including a lawyer or provider, to represent you and act on your behalf. You must sign a consent form allowing this person to represent you. Molina Healthcare does not cover any fees or payments to your representatives. That is your responsibility.

Before or during the appeal, you or your representative may request copies of all the documents in this appeal file, and the guidelines or benefit provisions used to make the decision. These will be sent to you free of charge. Molina Healthcare will send you our decision in writing within 14 calendar days, unless we tell you we need more time. Our review will not take longer than 28 calendar days. We will keep your appeal private.

If you or your provider wants a fast decision because your health is at risk, call (800) 869-7165 / TTY 711 for a quick review (called "expedited" review) of the denial. You may ask for a quick review if your physical or mental health is at serious risk or it involves a mental health drug authorization. You may file an expedited appeal either orally or in writing. If you file the expedited appeal orally, written follow up is not required. Molina Healthcare will contact you with our decision within 72 hours of getting your request for an expedited review.

If you ask for an expedited appeal, but Molina Healthcare decides your health is not at risk, we will follow the regular appeal timeframe. We will send you a letter telling you the decision and the reason for the change within two calendar days of your appeal request.

The expedited timeframe may be extended up to 14 calendar days if additional information to process your appeal is needed, and the delay is in your best interest. If Molina Healthcare extends the timeframe, we will send you a letter within two calendar days of your appeal request. We will tell you why the extension is needed. You can also ask for an extension.

STEP 2 – State Administrative Hearing: How do I ask for a legal review?

If you disagree with Molina Healthcare's appeal decision, you can ask for a State Administrative Hearing. You must complete Molina Healthcare's appeal process before you can have a hearing. You must ask for a hearing within 120 calendar days of the date on the appeal decision letter. When you ask for a hearing, you need to say what service was denied, when it was denied, and the reason it was denied. Your provider may not ask for a hearing on your behalf. You may ask for a quick decision if your health is at risk.

STEP 2: Ask for a State Administrative Hearing
Contact the Office of Administrative Hearings (OAH)
Phone: 1-800-583-8271
Address: P.O. Box 42489, Olympia, WA 98504-2489

You may consult with a lawyer or have another person represent you at the hearing. If you need help finding a lawyer, check with the nearest Legal Services Office or call the NW Justice CLEAR line at 1-888-201-1014 or visit their website at www.nwjustice.org.

You may ask for a quick decision if your health is at risk. A judge will make a decision within four working days after receiving the request. If the judge decides your health is not a risk, OAH will call you and send you a letter within four working days of the request. Your hearing will change to the standard timeframe.

STEP 3 - Independent Review: How do I ask for an Independent Review?

An Independent Review is a review by a doctor or specialist who does not work for Molina Healthcare. If you do not agree with the decision from the State Administrative Hearing, you can ask for an Independent Review within 21 calendar days of the hearing decision or you may go directly to Step 4. Call (800) 869-7165 / TTY 711 for help. You may ask for a quick decision if your health is at risk. Any extra information you want us to look at must be given to us within five working days of asking for the Independent Review. If you ask for this review, your case will be sent to an Independent Review Organization (IRO) within three working days. You do not have to pay for this review. Molina Healthcare will let you know the decision.

STEP 3: Ask for an Independent Review
Contact: Molina Healthcare
Phone: (800) 869-7165 / TTY 711
Fax: (877) 814-0342
Address: P.O. Box 4004, Bothell, WA 98041-4004

STEP 4 – Health Care Authority (HCA) Board of Appeals: How do I ask for another legal review?

You can ask for a final review of your case by the HCA Board of Appeals Review Judge. You must ask for this within 21 calendar days after the IRO decision is mailed. The decision of the HCA Board of Appeals is final.

STEP 4: Ask for a review by the HCA Board of Appeals
Phone: (360) 725-0910; Toll-free: (844) 728-5212 Fax: (360) 507-9018 Address: P.O. Box 42700, Olympia, WA 98504-2700

Other Information

Billed for services: If you get a bill for health care services, call (800) 869-7165/ TTY 711.

Second Opinion: At any time, you can get a second opinion about your health care or condition. Call (800) *869-7165/ TTY 711 to find out how to get a second opinion.*

Children under 21: The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are covered by Medicaid. MCO's are required to provide any additional health care services that are coverable under the Federal Medicaid program and found to be medically necessary to treat, correct, or reduce illnesses and conditions that are discovered. When a medically necessary covered service is denied, appeal rights will be provided. For children under the age of 21, the Exception to Rule (ETR) process does not apply.

Non-Covered Benefit

Exception to Rule: You or your provider may ask Molina Healthcare to approve a service that is not a covered benefit. For adults, this is called an Exception to Rule (ETR).

- It must be asked for before you get the service.
- To be approved, your provider must give us documentation that your condition is so different from most people.
- No other covered, less costly service will meet your need.
- The request must meet the rules in Washington Administrative Code (WAC) 182-501-0160 for approval.

ETR decisions are final and cannot be appealed.

Appeal: You may ask for an appeal, State Administrative Hearing, and then Independent Review to make sure we correctly determined the service is not covered. You can ask for an appeal at the same you or your provider asks for an Exception to Rule.

Limited Benefit:

Limitation Extension: Your provider may ask Molina Healthcare to approve more services for you than your benefit package allows. It may be more in scope, number, length of time, or how often a service is provided. An example is more adult physical therapy visits than the 12 visits the benefit allows. This is called a Limitation Extension (LE). To be approved, it must meet the rules in Washington Administrative Code (WAC) 182-501-0169:

- It must be asked for before you get more of the service.
- Your condition must show it is improving due to the services you have already received.
- Your condition must show it will likely continue to improve with more services, and that it will likely worsen without continued services.

You can ask for an appeal at the same time as your provider asks for a Limitation Extension.

Funding for some services is limited by available money: If you receive services that are paid for by Medicaid dollars, you have the right to appeal a decision that stops or limits those services. Some services are paid for with State-only or Federal block grant dollars. If the State-only or block grant money runs out, we cannot approve the service for you even if we agree the services are needed. There is no appeal process if a service is ended due to State-only or block grant money running out. You will be notified if this situation applies to you.

Provider Dispute Resolution Process

The Provider Dispute Resolution process (different from Appeals on behalf of Members) offers recourse for Providers who are dissatisfied with the payment or denial of a claim from Molina or any of its delegated medical groups/IPAs. Molina follows the Best Practice Recommendation for Extenuating Circumstances.

In the event a Provider would like to dispute a claim, the Provider may make an electric request via the Molina Portal, fax or e-mail: (1) within 24 months of Molina's original remittance advice date; (2) within 30 months after final determination by the primary payer. The Provider may not request payment be made any sooner than six months after Molina's receipt of the request. Any request for review of disputed claim must be submitted to Molina in accordance with the requirements stated in this section

Molina requires submission of your dispute through one of three options:

Provider WebPortal (portal login here)

To submit a dispute you will need to be in the Claims Status Inquiry module. Once you have identified the claim you are disputing you can click on the "Appeal Claim" button located at the bottom of the page. When you are ready to submit the dispute click on the "Submit" button.

The benefits of submitting your dispute request electronically via the WebPortal include:

- The member, claim number and provider information auto populate in the form
- Electronically attach chart notes or any other documentation as part of the dispute

- Type additional information you would like included in the text box regarding your dispute request. Specify why the Provider believes the services should be compensated or adjusted. If the service was denied for no prior authorization/notification you must include the extenuating circumstances as to why the prior authorization was not obtained
- In the case of coordination of benefits, include the name and mailing address of any entity that has disclaimed responsibility for payment including the denied EOB
- Receive an electric acknowledgment letter immediately following submission
- Free of charge, no more postage

Fax & Email

The Provider Dispute Resolution Request form must be completed with your request via e-mail or fax.

- Complete all elements of the Dispute Resolution Request form located at http://www.MolinaHealthcare.com/providers/wa/medicaid/forms/Pages/fuf.aspx. Including supporting medical records and any other required documentation for review of your request. Request forms that are incomplete or missing required information will not be reviewed and will be returned to the provider without review. Disputes submitted untimely from the original decision will be denied.
- If the dispute is regarding a claim denied for no prior authorization, you must include the extenuating circumstance as why authorization was not obtained. Extenuating Circumstances include; the inability to know member had Molina coverage, the inability to anticipate services in advance, inherent components where a service is essential to another, received misinformation from Molina, and untimely authorization decision from Molina. In the case of coordination of benefits, include the name and mailing address of any entity that has disclaimed responsibility for payment including the denied EOB. Include proof of due diligence including dated eligibility confirmation from another payer, such as eligibility screen shot and/or primary payers EOB showing denied services or ineligibility of coverage.

Additional information regarding extenuating circumstances can be found under the Best Practice Recommendation for Extenuating Circumstances.

- **Fax:** Molina Healthcare at (877) 814-0342
- **Email:** MHWProviderServicesInternalRep@MolinaHealthcare.com You must complete the Dispute Resolution Request form cover sheet located on the Provider Website under the Forms section at: http://www.MolinaHealthcare.com/providers/wa/medicaid/forms/Pages/fuf.aspx

If your claim was denied by a delegated medical group/IPA you must make your initial review request through that group. The delegated medical group/IPA addresses for dispute submission are located below. If you have a direct contract with the delegated medical group/IPA, their decision is final. All other second level reviews for providers not directly contracted with the medical group/IPA should be sent to Molina per the process above.

Molina has two levels for the dispute process. Third level dispute requests will be denied as the dispute process has been exhausted.

Request for provider disputes for medical group/IPA should be submitted to:

- Kaiser Foundation Health Plan of the Northwest:
  Kaiser Permanente NCA NW Claims
  Waterpark 1
  2500 Havana St.
  Aurora, CO 80014
  Fax: N/A

- Confluence Health:
  Molina Managed Care
  PO Box 810
  Wenatchee, WA 98807
  Fax: (509) 665-3606

The Provider will be notified of Molina's / delegated medical group IPA decision within 60 days of receipt of the provider dispute request. Providers are reminded they can NOT bill the Member when a denial for covered services is upheld.

Code Edit Policy Reconsiderations

A provider can request a reconsideration regarding a code edit policy in situations where the provider's and Molina Healthcare's correct coding policy sources conflict or where they may have different interpretations of a common correct coding policy source. The Provider will be notified of Molina Healthcare's decision in writing within 60 calendar days of the receipt of the Code Edit Reconsideration request, unless additional supporting documentation is required.

All requests for Code Edit Policy Reconsiderations must be submitted to Molina Healthcare in writing and should include the following:

- Explanation of why the provider does not agree with Molina Healthcare's current correct coding policy or interpretation. Include the supporting alternative policy information and the source where it can be found.
- Must clearly indicate "Code Edit Policy Reconsideration Request"
- Contact information for your organizations point person, i.e. name, contact number, e-mail address
- Relevant CPT/HCPCS codes or code combination examples
- Specific claim examples of denied services related to the code edit
- Must be addressed to the attention of Molina Healthcare's Provider Services Department

Code Edit Policy Reconsiderations do not apply to eligibility limitations, non-FDA approved services, medical policies, benefit determinations or contractual disputes. Code Edit Reconsiderations should be mailed, e-mailed or faxed to the addresses listed above under Provider dispute Process.

Reporting

All Grievance/Appeal data, is reported quarterly to Member/Provider Satisfaction Committee by the Department Managers for review and recommendation. A Summary of the results is reported to the Executive Quality Improvement Committee (EQIC) quarterly. Annually, a quantitative/qualitative report will be compiled and presented to the Member/Provider Satisfaction Committee (MPSC) and EQIC by the chairman of MPSC to be included in the organization's Grand Analysis of customer satisfaction and assess opportunities for improvement.

Appeals and Grievances will be reported to the State quarterly. Grievance and Appeals reports will be reviewed monthly by the Credentialing Coordinator for inclusion in the trending of ongoing sanctions, complaints and quality issues.

Record Retention

Molina will maintain all grievance and related appeal documentation on file for a minimum of ten (10) years. In addition to the information documented electronically via Call Tracking in QNXT or maintained in other electronic files, Molina will retain copies of any written documentation submitted by the Provider pertaining to the grievance/appeal process. Provider shall maintain records for a period not less than ten (10) years from the termination of the Model Contract and retained further if the records are under review or audit until the review or audit is complete. (Provider shall request and obtain Health Plan's prior approval for the disposition of records if Agreement is continuous.)

COMPLIANCE

Fraud, Waste, and Abuse

Introduction

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

Molina's Special Investigation Unit (SIU) supports Compliance in its efforts to deter and prevent fraud, waste, and abuse by conducting investigations aimed at identifying suspect activity and reporting these findings to the appropriate regulatory and/or law enforcement agency.

Mission Statement

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

Regulatory Requirements

Federal False Claims Act

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

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

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

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

Deficit Reduction Act

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

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 whistleblowers.

The Federal False Claims Act and State 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.

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

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

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

Definitions

Fraud: "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. An example would be the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome resulted in poor or inefficient billing methods (e.g. coding) causing unnecessary costs to the Medicaid program.

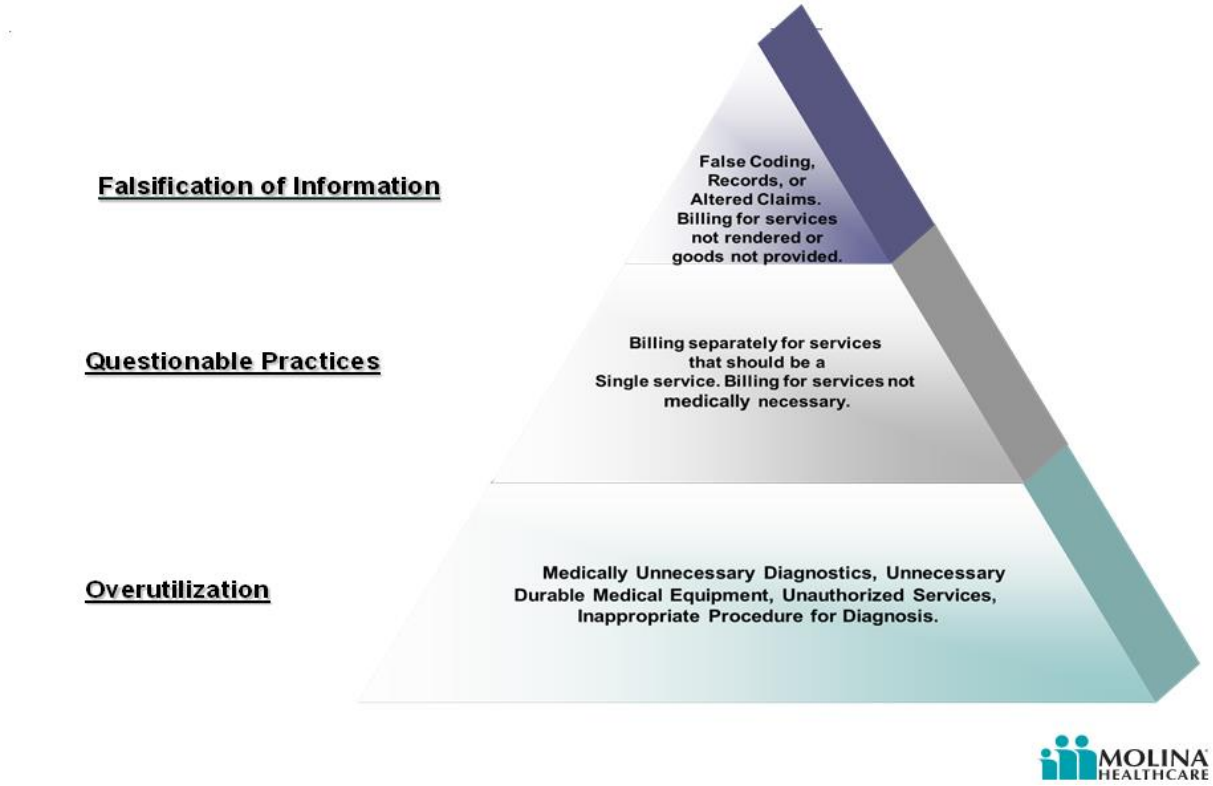
Abuse: Actions that may, directly or indirectly, result in: unnecessary costs to the Medicaid Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there 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 Provider knowingly and willfully referring a Member to health care facilities in which or with which the Provider has a financial relationship. (Stark Law)
- Altering Claims and/or medical record documentation in order to get a higher level of reimbursement.
- Balance billing a Molina Member for Covered Services. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees.
- Billing and providing for services to Members that are not Medically Necessary.
- Billing for services, procedures and/or supplies that have not been rendered.
- Billing under an invalid place of service in order to receive or maximize reimbursement.
- Completing certificates of Medical Necessity for Members not personally and professionally known by the Provider.
- Concealing a Member's misuse of a Molina identification card.
- Failing to report a Member's forgery or alteration of a prescription or other medical document.
- False coding in order to receive or maximize reimbursement.
- Inappropriate billing of modifiers in order to receive or maximize reimbursement.
- Inappropriately billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement.

- Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients.
- Not following incident to billing guidelines in order to receive or maximize reimbursement.
- Overutilization
- Participating in schemes that involve collusion between a Provider and a Member that result in higher costs or charges.
- Questionable prescribing practices.
- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code.
- Underutilization, which means failing to provide services that are Medically Necessary.
- Upcoding, which is when a Provider does not bill the correct code for the service rendered, and instead uses a code for a like services that costs more.
- Using the adjustment payment process to generate fraudulent payments.



Examples of Fraud, Waste, and Abuse by a Member

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

- Benefit sharing with persons not entitled to the Member's benefits.
- Conspiracy to defraud 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 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 performed 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'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 under the Provider Agreement or at Law or equity. In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement, the parties agree that Molina shall in its sole discretion exercise the terms that are expressed in the Provider Agreement, the terms that are expressed here, its rights under Law and equity, or some combination thereof.

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

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

Provider acknowledges that HIPAA specifically permits a covered entity, such as Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 154.501). Provider further acknowledges that in order to receive payment from Molina, Provider is required to allow Molina to conduct audits of its pertinent records to verify the services performed and the payment claimed, and that such audits are permitted as a payment activity of Provider under HIPAA and other applicable privacy Laws.

Provider Education

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

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

Reporting Overpayments or Fraud, Waste and Abuse

Federal and state laws and regulations require providers who participate in the Medicaid and CHIP programs to conduct self-audits for possible overpayments. When an overpayment is identified, a provider must submit repayment to Molina within 60 days of recovery.

If you have any questions regarding how to refund an overpayment, please call the Claims Recovery Department at (866) 642-8999.

In the event the provider receives a check that is not theirs or finds an overpayment, please send the refund with a copy of the remittance advice and claim information to:
Molina Healthcare of Washington, Inc.
PO Box 30717
Los Angeles, CA 90030-0717

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina AlertLine. AlertLine is an external telephone and web based reporting system hosted by NAVEX Global, a leading Provider of compliance and ethics hotline services. AlertLine telephone and web based reporting is available 24 hours a day, 7 days a week, 365 days a year. When you make a report, you can choose to remain confidential or anonymous. If you choose to call AlertLine, a

trained professional at NAVEX Global will note your concerns and provide them to the Molina Compliance Department for follow-up. If you elect to use the web-based reporting process, you will be asked a series of questions concluding with the submission of your report. Reports to AlertLine can be made from anywhere within the United States with telephone or internet access.

Molina AlertLine can be reached toll free at 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 using one of the below options. You have the right to have your concerns reported anonymously without fear of retaliation.

Molina Healthcare of Washington
Attn: Compliance
P.O. Box 4004
Bothell, WA, 98041-4004
Fax: (800) 282-9929

Remember to include the following information when reporting:

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

Suspected fraud and abuse may also be reported directly to the State at: Washington Health Care Authority

Attn: Office of Program Integrity
626 8th Ave SE / P.O. Box 45503
Olympia, WA 98504-5503
Phone: (800) 562-6906
Fax: (360) 586-0212
Online: https://www.hca.wa.gov/about-hca/medicaid-fraud-prevention

Office of the Attorney General Attn: Medicaid Fraud Control Division
P.O. Box 40114
Olympia, WA 98504
Phone: 360-586-8888
Fax: (360) 586-8888
Online: http://www.hca.wa.gov/about-hca/program-integrity

HIPAA Requirements and Information

HIPAA (The Health Insurance Portability and Accountability Act)

Molina's Commitment to Patient Privacy

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

Provider Responsibilities

Molina expects that its contracted Provider will respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member PHI. Molina provides its Members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how Molina uses and discloses their PHI and includes a summary of how Molina safeguards their PHI.

Telehealth/Telemedicine Providers: Telehealth transmissions are subject to HIPAA-related requirements outlined under state and federal law, including:

- 42 C.F.R. Part 2 regulations
- Health Information Technology for Economic and Clinical Health Act, ("HITECH Act")

Applicable Laws

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

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

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

Uses and Disclosures of PHI

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

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

entity to another covered entity, or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

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

Confidentiality of Substance Use Disorder Patient Records

Federal Confidentiality of Substance Use Disorder Patients Records regulations apply to any entity or individual providing federally-assisted alcohol or drug abuse prevention treatment. Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with substance use disorder treatment or programs are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects substance use disorder information, the Federal Confidentiality of Substance Use Disorder Patients Records regulations are more restrictive than HIPAA and they do not allow disclosure without the Member's written consent except as set forth in 42 CFR Part 2.

Inadvertent Disclosures of PHI

Molina may, on occasion, inadvertently misdirect or disclose PHI pertaining to Molina Member(s) who are not the patients of the Provider. In such cases, the Provider shall return or securely destroy the PHI of the affected Molina Members in order to protect their privacy. The Provider agrees to not further use or disclose such PHI and further agrees to provide an attestation of return, destruction and non-disclosure of any such misdirected PHI upon the reasonable request of Molina.

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

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 Providers must allow patients to exercise any of the below-listed rights that apply to the Provider's practice:

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

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

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

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

5. **Request to Amend PHI**
   Patients have a right to request that the Provider amend information in their designated record set.

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

HIPAA Security

Providers must implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of Molina Member and patient PHI. As more Providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate cyber security measures. Providers should recognize that identity theft – both financial and medical -- is a rapidly growing problem and that their patients trust their health care Providers to keep their most sensitive information private and confidential.

Medical identity theft is an emerging threat in the health care industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity –such as health insurance information—without the person's knowledge or consent to obtain health care services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to Molina.

HIPAA Transactions and Code Sets

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

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

Molina is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers should refer to Molina's website at www.MolinaHealthcare.com for additional information regarding HIPAA standard transactions.

1. Click on the area titled "I'm a Health Care Professional"
2. Click the tab titled "HIPAA"
3. Click on the tab titled "HIPAA 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 and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within thirty (30) days and should also be reported to Molina within thirty (30) days of the change. Providers must use their NPI to identify it on all electronic transactions required under HIPAA and on all Claims and Encounters submitted to Molina.

Additional Requirements for Delegated Providers

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

Reimbursement for Copies of PHI

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

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

Molina Authorization for Use and Disclosure of Protected Health Information form can be found here:
https://www.molinahealthcare.com/providers/wa/medicaid/forms/PDF/forms_wa_Authorization_for_use_or_disclosure_of_PHI.pdf

FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs) AND RURAL HEALTH CLINICS (RHCs)

The Health Care Authority (HCA) pays a monthly amount, known as an enhancement rate, to clinics designated and approved as FQHCs and RHCs.

These enhancement rates are paid to the Managed Care Organization (MCO) by the HCA to pass along to the clinics. Each FQHC and RHC is responsible to notify Molina of any Provider enrollment changes (additions and terminations) at the clinic. Members are assigned to individual Primary Care Providers (PCP's) at the respective clinic.

PMPM Premium Enhancement

All FQHC and RHC clinics receive this premium enhancement rate established annually by HCA. Molina Healthcare submits monthly eligibility rosters to HCA, listing all Members assigned to PCPs for each of its contracted FQHCs and RHCs. HCA determines its PMPM payment based on that roster. Any payment discrepancies identified by Providers must be addressed to HCA.

Rural Health Clinic Encounter Payment

Effective January 1, 2018 Molina will pay RHC's for encounter claims submitted directly to Molina if the RHC opted to have the MCO pay the encounter rate versus the HCA.

For RHC's that bill Molina directly for their encounter rate, they must follow the below guidelines for timely and accurate payment:

- Encounters are limited to one type of encounter per day for each client except in either one of the following circumstances:
  - It is necessary for the client to be seen by different practitioners with different specialties.
  - It is necessary for the client to be seen multiple times due to unrelated diagnoses.
- If you are billing more than one encounter per day, they must be billed on separate claims. Due to our system requirements only one encounter rate can be paid per claim. This would also include Maternity care. On each claim, indicate it is a separate encounter, enter "unrelated diagnosis" and the time of both visits in the Claim Note section of the electronic claim (modifiers 25, 59, XE, XP signify two billable visits).
- Submit professional claims with T1015 for visits that qualify as an encounter for place of service 11 or 72. **T1015 must be the last code listed on the claim** and billed as one unit in order for our system to pay your encounter claim correctly.
- Claims must be submitted using the National Provider Identifier (NPI) posted on the HCA's website as the billing NPI.

For services eligible for encounter payment, our system will automatically pay the difference between your RHC encounter rate and your Molina contracted fee for service amount paid on the T1015 line when the Molina contracted fee for service amount paid is less than the encounter rate. At this time we are not able to process claims with a negative amount on the claim line with T1015. If the Molina contracted fee for service amounts add up to more than the encounter rate, the system will cap payment at the encounter rate and there will be zero payment on the claim line with T1015.

Molina will follow the same guidelines regarding what services provided by an RHC are considered an encounter. For additional information please reference the HCA, RHC provider guide and encounter rates at https://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates- and-billing-guides#r

DELEGATION - MEDICAL GROUP/IPA OPERATIONS

This section contains information specific to Molina's delegation criteria. Molina may delegate certain administrative responsibilities upon meeting all of Molina's delegation criteria. Molina is accountable for all aspects of the Member's health care delivery, even when it delegates specific responsibilities to sub-contracted entities. Molina's Delegation Oversight Committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements.

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

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.

For a quick reference, the following table reflects the Claims and Referral/Authorization contact information for all medical groups/IPAs currently delegated for Claims payment and/or UM functions for the Medicaid lines of business.

IPA / CAP Group Name	ID Card Acronym	CAP Lines of Business	Claims Remit to Address	Referral / Authorization Information
Kaiser Foundation Health Plan of the Northwest	KPNW	IMC-AH (IMC Apple Health) IMC-AHA (IMC Apple Health Adult) IMC-BD (IMC Apple Health Blind Disabled) IMC-PREM (IMC	Physical Health Services only: Waterpark 1 2500 Havana St Aurora, CO 80014 Behavioral Health Services including	For Physical Health Services KPNW: Phone: (800) 813-2000 Fax: (877) 800-5456 For Behavioral Health Services including Mental Health and Substance use

IPA / CAP Group Name	ID Card Acronym	CAP Lines of Business	Claims Remit to Address	Referral / Authorization Information
		Apple Health w Premium)	Mental Health and Substance use disorder: Molina Healthcare PO Box 22612 Long Beach, Ca 90801	disorder Molina Healthcare: Phone: (800) 869-7185 Fax: (800) 767-7188
Kaiser Foundation Health Plan of the Northwest	KPNW	AHPREM (Apple Health with Premium) AHFAM (Apple Health Family/Pregnancy Medical) AHA (Apple Health Adult) AHBD (Apple Health Blind Disabled)	Physical Health Services and Behavioral Health Services: Waterpark 1 2500 Havana St Aurora, CO 80014	Physical Health Services and Behavioral Health Services KPNW: Phone: (800) 813-2000 Fax: (877) 800-5456

NOTE: The Member's Molina Healthcare ID card will identify the group the Member is assigned to by the acronyms listed above. If Claims payment and/or UM has been delegated to the group, the ID card will show the delegated group's remit address and phone number for prior authorizations.

ATTENTION: The below references for Confluence Health CAP are effective only for Dates of Service (DOS) through Dec 31, 2018. For dates of service on and after Jan 1, 2019 submit all claims and prior authorization requests to Molina Healthcare of WA for processing (see Claims and Compensation and Healthcare Services sections).

Date of Service	IPA / CAP Group Name	ID Card Acronym	CAP Lines of Business	Claims Remit to Address	Referral / Authorization Information
Through 12/31/18	Confluence Health	Confluence Health CAP	AHPREM (Apple Health with Premium) AHFAM (Apple Health Family/Pregnancy Medical) AHA (Apple Health Adult)	PO Box 810 Wenatchee, WA 98807-0810 OR EDI Payor #: 91064	Confluence Health: Phone: (800) 691-1224 Fax: (509) 665-4707
Through 12/31/18	Confluence Health	Confluence Health CAP	IMC-AH (IMC Apple Health) IMC-AHA (IMC Apple Health Adult) IMC-PREM (IMC Apple Health w Premium)	Physical Health Services only: PO Box 810 Wenatchee, WA 98807-0810 OR	Physical Health Services: Confluence Health: Phone: (800) 691-1224 Fax: (509) 665-4707 For Behavioral Health Services

Date of Service	IPA / CAP Group Name	ID Card Acronym	CAP Lines of Business	Claims Remit to Address	Referral / Authorization Information
				EDI Payor #: 91064 Behavioral Health Services including Mental Health and Substance use disorder: Molina Healthcare PO Box 22612 Long Beach, Ca 90801 or EDI Payor #: 38336	including Mental Health and Substance use disorder Molina Healthcare: Phone: (800) 869-7185 Fax: (800) 767-7188

The below table shows all contracted PCP capitated groups. These groups receive a per member per month capitation payment to manage all primary care services only for their assigned membership. When seeing a new member verify if the member is assigned to a PCP capitated group by looking at their ID card or verifying eligibility on the web portal. If the member is assigned to a PCP capitated group the member must be seen by their assigned PCP or a PCP change needs to be made to the appropriate PCP prior to services being rendered.

PCP CAPITATION GROUPS	ACRONYM
Community Health Associates Spokane	CAP - CHAS
Family Care Network	CAP - FCN
Moses Lake Community Health Center	Cap – MOSES LAKE CHC
Pacific Physicians	CAP – PACIFIC PHYSICIANS
Pierce Unicare IPA	CAP – PIERCE UNICARE
Rose Medical Group	CAP – ROSE CLINIC
Yakima Valley Farmworkers Clinic	CAP - YVFWC

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.

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 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 correction 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 thirty (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 with a score of at least 90%, 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 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 depends on the type of Certification or Accreditation the Medical Group, IPA, or Vendor has, but will always include evaluation of applicable state requirements and Molina business needs.

If the 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.

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 with a score of at least 90%.
- 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.

Capitation Models

Molina Healthcare employs a variety of Capitation reimbursement models; only organizations or individuals with a significant number of Members to spread the financial risk are approved for capitation contracts.

Primary Care Capitation: An individual PCP or a group of PCPs receive a monthly prepaid amount from Molina Healthcare as compensation for a contractually defined set of services, which are designated as capitated by Molina Healthcare.

Full Risk/Global Capitation: IPA or PHO receives a monthly prepaid amount from Molina Healthcare as compensation for a contractually defined set of services, which are designated as capitated by Molina Healthcare. These services are typically global in nature (i.e., these groups

have assumed financial responsibility for all covered health care services unless specifically carved out by Molina Healthcare). Financial responsibility for all services (including carve outs) is defined in the financial responsibility matrix attached to the full risk/global Capitation agreement.

Financial Viability of Capitated Organizations

Molina Healthcare is obligated to monitor the financial status of the groups to whom it has given financial risk. This is a contractual and business responsibility. We use all reasonable methods to prevent placing an organization at risk for more than they are able to manage. We work to ensure there is little risk to any Providers who would look to the organization for payment of Claims. Prior to the initial contracting under a capitation model with an organization, Molina Healthcare assesses the organization's financial condition by reviewing the two most recent years audited financial statements and year-to-date unaudited financial statements for the current year.

Physician Incentive Plan (PIP)

Every year, Molina Healthcare is required to submit a report to HCA disclosing incentive terms for all Provider contracts. For Providers/Provider groups with substantial financial risk (any organization that could be adversely or positively affected financially by the referral volume of its Members), Molina Healthcare is required to disclose additional documentation. Organizations with substantial financial risk must provide information to Molina Healthcare including:

- Mode of payments to Providers and any payment plans considered to be PIPs
- Evidence of stop-loss protection
- Evidence of annual Member satisfaction surveys

Reporting Requirements of Organizations

Once contracted, Molina Healthcare expects all organizations, identified as bearing substantial financial risk on the PIP, to submit the following documents to Molina Healthcare:

Complete quarterly financial statements including:

- Balance Sheet
- Income Statement
- Statement of Cash Flows
- Audited annual financial statements

Organizations delegated for Claims may have additional reports required to assist Molina Healthcare in fulfilling its financial oversight responsibilities.

Capitation Operations

Joint Operations Committee Meetings: Molina Healthcare is available to meet as needed to address operational or contractual issues. On a quarterly basis, Molina Healthcare tries to meet with each of its organizations that operate under a capitation model. The purpose of the meetings is to:

- Identify any operational difficulties between the organization and Molina Healthcare and determine plans for a remedy
- Educate one another on changes to either the organization or Molina Healthcare
- Provide an opportunity for staff to meet their counterparts in order to facilitate more productive interactions

The meetings are facilitated by the Provider Services Representative, but include any other Molina Healthcare staff who may be pertinent to issues at hand.

Funds Flow Document: Because the contract is a lengthy and somewhat complicated document, Molina Healthcare works with the capitated organization to write a Funds Flow document outlining:

- Payment rates
- Mode of payment
- Division of financial responsibility
- Any special payment arrangements

The purpose of this document is to provide all involved staff at the organization and Molina Healthcare with a guide for adhering to the terms of the contract.

Encounter Reporting

Each capitated organization delegated for Claims payment is required to submit encounter data for all adjudicated Claims. The data is used for many purposes, such as reporting to the Medicaid Statistical Information System (MSIS), Apple Health rate setting and risk adjustment, HCA's hospital rate setting, the quality improvement program and HEDIS reporting.

The encounter data reporting specifications can be found at http://www.MolinaHealthcare.com/providers/common/medicaid/ediera/edi/Pages/guidanceinfo.as px.

CULTURAL COMPETENCY AND LINGUISTIC SERVICES

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. 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, non-verbal, have a speech impairment or have an intellectual disability. Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds 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

Nondiscrimination of Healthcare Service Delivery

Molina complies with the guidance set forth in the final rule for Section 1557 of the ACA, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina website home pages. All Providers who join the Molina Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Molina requires Providers to deliver services to Molina Members without regard to race, 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 can refer Molina Members who are complaining of discrimination to the Molina Civil Rights Coordinator at: (866) 606-3889, or TTY, 711.

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

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

Cultural Competency

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

Provider and Community Training

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

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

1. Written materials;
2. On-site cultural competency training;
3. Online cultural competency provider training; 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, 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 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 (Community Health 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.

24 Hour Access to Interpreter Services

All eligible Members who are Limited English Proficient (LEP) are entitled to receive interpreter services for all types of appointments and for assisting in filing a complaint or appeal through the Health Care Authority (HCA) at no cost to the Member. An LEP individual may have a limited ability or inability to read, speak or write English well enough to understand and communicate effectively.

Molina Providers must support Member access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset. Please remember it is never permissible to ask a family member, friend or minor to interpret.

Providers are responsible for assuring interpreter services are made available. If you would like to arrange for interpreter services you must use a broker that is contacted with HCA. If you would like to obtain a current list of contracted brokers by county, please go to, http://www.hca.wa.gov/billers-providers/programs-and-services/interpreter-services or E-mail: interpretersvcs@hca.wa.gov

All eligible Members who are Limited English Proficient (LEP) are entitled to receive interpreter services. Pursuant to Title VI of the Civil Rights Act of 1964, services provided for Members with LEP, LRP or limited hearing or sight are the financial responsibility of the Provider. Under no circumstances are Molina Members responsible for the cost of such services. Written procedures are to be maintained by each office or facility regarding their process for obtaining such services. Molina is available to assist Providers with locating these services if needed.

Documentation

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

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

Members who are Deaf or Hard of Hearing

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

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

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

Nurse Advice Line

Molina provides twenty four (24) hours/seven (7) days a week Nurse Advice Services for members. The Nurse Advice Line provides access to twenty-four (24) hour interpretive services. Members may call Molina 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.

BENEFIT INDEX

Benefit Index Apple Health – Effective January 1, 2019

https://www.molinahealthcare.com/providers/wa/medicaid/manual/PDF/16-benefit-index-apple-health-effective-2019.pdf

Benefit Index Apple Health IMC and BHSO – Effective January 1, 2019

https://www.molinahealthcare.com/providers/wa/medicaid/manual/PDF/17-benefit-index-imc-effective-July-2019.pdf